State of Nevada
Division of Mental Health
And Developmental Services

2002 Biennial Report

Produced by
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Division Program Evaluation/IT Manager

January 2003

DIVISION ADMINISTRATOR,
CARLOS BRANDENBURG, PH.D.

DEPUTY ADMINISTRATOR
DEBBIE HOSSELKUS, LSW

Governing Bodies

Nevada Commission on Mental Health and Developmental Services

David Ward, Chairman
Eric C. Albers, Ph.D., Vice Chair

Representing Social Workers
Eric C. Albers, Ph.D.

Representing Registered Nurses
Joan McCraw, MSN, RN, FNP

Representing Psychologists
Elizabeth C. Richitt, Ph.D.

Representing General Public-DS
David Ward

Representing Physicians
Johanna Fricke, M.D.

Representing Psychiatrists
Rena Nora, M.D.

Representing General Public-MH
Gretchen Greiner

Representing Marriage & Family Therapist
John C. Brailsford, Ph.D.

Mental Health Planning and Advisory Council

Consumer/Family Member
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Alyce Thomas

Law Enforcement Vice Chair
Mike Doyle

Family Member
Nancy Aitken

Consumer
Bob Bennett

DHCFP – Medicaid
Dave Caloiaro

DCFS
Jerry Clark

Consumer
Wendy Cooley

MHDS
Kevin Crowe

Health Division
Richard Whitley

Department of Education
Gloria Dopf

Consumer
Barbara Jackson

Family Member
Rosetta Johnson

Member/Representation
Barbara Legier
Rehabilitation Division

Housing Division
Debra Parra

Consumer
Jenita Rodriguez

Family Member
Karen Taycher

Family Member
Anna Uptergrove

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MHDS 2002 Biennial Report

The Division of MHDS provides a variety of inpatient and outpatient services to best meet the changing needs of Nevadans

This report provides a biennial summary of services and activities. Reports concerning strategic planning, medication, needs assessment and other topics can be accessed. For further information regarding the Division of MHDS and any of it's agencies, please visit our website at:

http://mhds.state.nv.us/

FROM THE ADMINISTRATOR

The US Congress declared the 1990's the "Decade of the Brain".

"The 1999 White House Conference on Mental Health called for a national antistigma campaign. The Surgeon General issued a call to action for suicide prevention in 1999 as well."

"We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health."

President Bush established the "New Freedom Commission on Mental Health".
The commission was established as part of the President's agenda to ensure that American's with mental illness not fall through cracks, that lives not be lost, and that recovery be a realistic goal of treatment.

Senator Randolph J. Townsend was selected by the President to serve as a Commissioner on his New Freedom Commission on Mental Health..

New Beginnings Characterized The Past Two Years

It is with great pleasure that I present to you our third Biennial Report. This is our Division's premiere report and is published every other January; designed to be made available with our most recent data in time for each session of the Nevada Legislature.

This report can give the reader a clear overview of the Division's programs, and understanding of our accomplishments and major new plans for the next two years. You may also get to know the citizens we serve.

This report generally covers the past two years ending July 1,2002, sometimes referred to as a "biennium". While a key audience for this report are Governor Guinn, DHR Director Mike Willden and our Legislators during the upcoming January-June 2003 session, we also provide this report for many other interested individuals as well.

During these past two years, our programs can be characterized by continuing key services to Nevadan's who have mental illness or are developmentally disabled, the development of new and innovative programs and by overall increasing consumer demand. Nowhere is this more apparent than with new programs such the mental health Consumer Assistance Program, and new intensive residential supports for use with clients who are being discharged from Nevada's legal system.

These past two years have been a time of new beginnings. Construction was completed at Lakes Crossing Center for the Mentally Disordered Offender in Sparks NV, which increased our forensic bed capacity from 36 to 48. We also opened a new state of the art psychiatric hospital in Northern Nevada in September 2001, named the Dini-Townsend Hospital.

We made other systemic changes too; for example, the 2001 Nevada Legislature authorized renaming the old Nevada Mental Health Institute to the Northern Nevada Adult Mental Health Services (NNAMHS). This name change reflects our commitment to move Nevada's system of care forward from an obsolete institutional treatment model where people were separated from family and community in distant castle like buildings away from social events and friends to a community-based system of care.

Support from Governor Guinn and the 2001 Legislature enabled MHDS to provide new community-based mental health programs to

assist those consumers who rely on our outpatient services. The Division FY02-FY03 biennium budget was funded for $52,625,564 more than the preceding biennium an increase of 23.37%. All MHDS programs are intended to reduce the need for hospitalization and foster consumer recovery in the community. Our programs are designed to insure we meet the intent of the *Olmstead* decision. The federal act resulting from this decision was geared to require a State to move people from an institutional setting to a community setting with all reasonable speed to accommodate the change in placement. Among these outpatient programs and special highlights are:

- Programs for Assertive Community Treatment (P.A.C.T.) continue to provide highly specialized services for the most seriously mentally ill residing in the community setting. The PACT model has demonstrated effectiveness for the most severely mentally ill (SMI) who comprise 20 to 40 percent of the SMI population. These consumers include those who have major psychiatric symptoms that may only partially improve but who can be maintained in the community with medication and the intensive treatments offered through the P.A.C.T. program. New for this year, we added substance abuse counselors to these programs so that the unique needs of these individuals can be more effectively met. Our P.A.C.T. programs clearly have met the goal of reducing hospital recidivism.

- Supported housing services at SNAMHS currently serve 584 indigent seriously mentally ill clients. Priority is given to patients recently discharged from our inpatient psychiatric hospital. Placement levels include, among others, intensive supported living arrangements (ISLA) and special needs beds. Intensive supportive living arrangements (ISLAs) provide 24-hour awake supervision of clients who otherwise would require inpatient hospital care. These services are provided in independent apartment community settings with additional individualized support services based on client needs and choice. In addition, 'Special needs' beds provide independent apartment community settings for medically compromised mentally ill clients who require additional nursing supervision. These placements provide service to clients who otherwise would have remained in the inpatient psychiatric hospital only because self care of their medical condition is compromised by mental illness.

- Nevada's first-ever Consumer Assistance Program began in June 2002, providing the employment of six mental health consumers as state employees to facilitate consumer recovery and integrate consumers into the service delivery system.

FROM THE ADMINISTRATOR

MHDS Strategic Plan Goal #1:

Provide and promote high quality and cost effective services in a safe environment

Data Excerpts from the NASMHPD Research Institute Report Draft:

"Funding Sources and Expenditures of State Mental Health Agencies in Fiscal Year 2001":

MHDS spent 1% of their total expenditures on Administration compared to the National average of 4.1%.

MHDS expenditures for Inpatient Services were 29% of the total expenditures Compared to the national average of 39%.

FROM THE ADMINISTRATOR

Vision

For all Nevadans with mental illness or developmental disabilities to realize their optimal potential as individuals and as positive productive citizens of their community and state.

- NNAMHS consumer classroom offered for the first time brand new computers for consumers in a classroom setting, to let them gain skills so they can return to work.

- Provided substantial funding increases from FY01 for the prescription of the newer and safer anti-depressants and antipsychotic (AAP's) medications. In FY02, the MH medication budget was $11,157,803 which was 15.70 % of the total budget. For comparison, FY01 was budgeted at $7,955,095 or 13.19% of the budget.

- A Mental Health Court was established in Washoe County, whereby certain mentally ill offenders who volunteer for the special court receive a mental health treatment program instead of jail time for minor offenses. They must check in with the court regularly. The Washoe County court has succeeded in part because judges volunteer their lunch time once a week to hear cases. Recent data shows it has reduced repeat offenders. Five of the 32, or about 15 percent of the mentally ill offenders who have participated the Washoe special court have had their probation revoked. Assemblywoman Sheila Leslie, D-Reno, sponsored the state bill that created the pilot program in Washoe County.

- We expanded our mental health program for senior citizens in Southern Nevada into Northern Nevada (Reno). This program is a collaborative effort between the Division of Mental Health and Developmental Services, the Division of Aging Services and the Bureau of Alcohol and Drug Abuse. The goal of both the Northern and Southern Senior Outreach Programs is to improve the mental health service delivery system for elder Nevadans. The target population is older adults who have undiagnosed and untreated illnesses such as depression and alcoholism. These senior outreach programs seeks to impact on the staggering rates of suicide in Nevadans aged 65 and older.

- The Division continues to update its Division wide Mental Health disaster response plan. This plan continues to be called into use, and over the past two years was utilized to provide crisis mental health services to Nevadans in emergencies as the result of wildfires and other small scale disasters;
particularly the Walker (CA) River Wildfire during the Summer of 2002, during which the tragic crash of the rescuing Forest Service air tanker into the community distressed the
population of the small town on the Nevada-California border. Our staff even worked alongside professionals from Placer County (CA) mental health to respond to the interstate needs of the Walker community.

- Over the past two years, we have all become affected by

terrorism in our country. Even here in Nevada our programs were directly affected by the September 11, 2001 tragedy at the New York World Trade Center; as we were called upon to send NV mental health professionals to assist there, and placed others on standby. We were ready to help.

- Over the past two years we have put in place a new website, which was recognized as a national model in 2002 for its user friendliness. Visit us at http://mhds.state.nv.us.

During 2001-02, we also saw the advancement in our programs for the developmentally disabled; Accomplishments in our DS programs include:

- The rapid expansion of DS services to people who were on waiting lists.
- All new residential supports are now being provided in the community.
- Service offices have been added in Winnemucca, Silver Springs and Las Vegas. New satellite offices provide better local access for service coordination
- Sierra Regional Center in Reno received national accreditation by the council for outstanding services.
- Expansion of In-Home Supported Living Services to enable families who previously asked for out-of-home placement to keep their relatives at home.

In closing, I am proud of our progress since our last report in 2000. But while these past years have seen many accomplishments, clearly the future is unfolding as a time for wise planning to meet tomorrows challenges.

Now, more than ever, the participation of our stakeholders is required to move our programs ahead cost effectively. More than ever, we need and appreciate your support.

Sincerely,

Carlos Brandenburg
Administrator

FROM THE ADMINISTRATOR

DIVISION ADMINISTRATOR, CARLOS BRANDENBURG, PH.D.

Dr. Brandenburg received his Ph.D. from the University of Nevada, Reno.
As the Administrator of the Division of Mental Health and Developmental Services, he supervises over 1100 employees and a budget of over 225 million dollars.
In 1995, when Dr. Brandenburg became the Administrator for the Division, Nevada was ranked 49th in actual dollars and per capita expenditures. As of 1999, Nevada is now ranked 35th.

MHDS MISSION

Our mission statement is an invaluable tool for directing, planning and achieving the Goals of the Division of MHDS.

In coordination with the mission statement, budgets are developed to assist with meeting the goals of the Division as well as ensure that we meet the needs of Nevada consumers.

Mission Statement for the Division of Mental Health and Developmental Services

Working in partnership with consumers, families, advocacy groups, agencies and diverse communities, the Division of Mental Health and Developmental Services provides responsive services and informed leadership to ensure quality outcomes. This mission includes treatment in the least restrictive environment, prevention, education, habilitation and rehabilitation for Nevadans challenged with mental illness or developmental disabilities. These services shall maximize each individuals' degree of independence, functioning and satisfaction.

Division of Mental Health and Developmental Services Overview

The Division of Mental Health and Developmental Services (MHDS) provides services to over 25,000 Nevadans, (22,341 Mental Health clients and 3153 Developmental Services clients (total = 25,494 in Fiscal Year 2002) across 96,000 square miles of Nevada in both urban and rural areas. This is an increase of 9% from FY 2001. In addition to these direct consumers, the Division works with many stakeholders, including family members, advocates, service providers, legislators, the general public, and law enforcement. As a result of these diverse interests, the issues facing the Division in addition to being complex, are also viewed from many different perspectives. The underlying thread of unity in this diverse system, however, is the commitment of all stakeholders to a public mental health/developmental services system that meets the needs of Nevada's citizens.

The Division of MHDS is responsible for the operation of state funded outpatient community mental health programs, psychiatric inpatient programs, mental health forensic services and all developmental services programs and facilities. By statute, the Division is responsible for planning, administration, policy setting, monitoring and budget development of all state funded mental health and developmental services programs. The Division Administration is also directly involved in decisions regarding agency structure, staffing, program and budget development. The mission of the Division is to develop and operate programs which assist individuals who have mental illness or developmental disabilities to live as independently as possible. The Division is obliged to offer care regardless of ability to pay, assure services are offered in the "least restrictive environment," base services upon individual needs, and honor consumers rights. The Division is committed to providing quality cost effective services that ensure consumer and citizen safety, are readily accessible to all persons in need, are responsive to local needs, are consumer-driven and promote self-sufficiency.

The MHDS Division is located within the Department of Human Resources. The Division Administrator, appointed by the Governor, relies on the oversight and direction of stakeholders as represented in several advisory groups. A Commission on Mental Health and Developmental Services is appointed by the Governor and "establishes policies to ensure adequate development and administration of services for the mentally ill, developmentally disabled and related conditions …" The Commission has several powers related to the oversight of programs within the Division. Local Advisory Boards exist within each region by authority of the Commission and are involved with local agency issues. Administration and services are organized into three regions: North, South and Rural.

DIVISION OVERVIEW

"Mental disorders collectively account for more than 15% of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer"

Disease burden by selected illness categories in established market economies, 1990

	% of total DALYS*
All cardiovascular conditions	18.6
All mental illness **	15.4
All malignant disease	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious/ parasitic disease	2.8
All drug use	1.5

*Disability-adjusted life year. (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration. (Murray&Lopez,1996)

**Disease burden associated with mental illness includes suicide

MHDS
Strategic Plan
Goal #2:

Promote and support the least restrictive services possible in people's own communities while reducing reliance on institutional placement.

Strengthen community-based services to support people with multiple and complex needs.

Mental Health:

The Division actual MH expenditures for Fiscal Year 2002 were $73,948,646 with 729 positions (FTE) funded. This is an increase of 24.6% over the Fiscal Year 2001 actual expenditures of $59,316,395. It is also a net increase of 3 new positions.

A full range of adult mental health services are provided by the Division which are categorized into the following programs by agency:

NNAMHS: Inpatient Services, Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, Residential Programs, Psychiatric Emergency Services and Program for Assertive Community Treatment (PACT).

Rural Clinics: Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, and Residential Programs. Rural Clinics also provides services to children and youth.

SNAMHS: Inpatient Services, Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, Residential Programs, Psychiatric Emergency Services, Intensive Service Coordination, Senior Outreach and Program for Assertive Community Treatment (PACT).

Lake's Crossing Center (LCC): Nevada's only forensic facility, providing mental health treatment for the mentally disordered offender in a maximum security setting

Since 1992, youth services have been incorporated into a separate Division of Child and Family Services within the Department of Human Resources. DCFS administers family support services, child care licensing, juvenile justice and an array of treatment services for youth in the urban areas of Clark and Washoe counties. However, in the remaining 15 rural counties, these youth services are offered via the Mental Health Division's system of rural clinics.

Since 1998, the foremost mental health service priority within the Division has been to provide services to consumers with serious mental illness (SMI). The Division in FY 97 revised the Nevada Administrative Code (NAC) to expand the state definition of seriously mentally ill. The definition for serious mental illness in the Nevada Administrative Code (NAC) reads:

> " Adults with a serious mental illness are persons 18 years of age and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that meets DSM criteria (excluding the substance abuse or addictive disorders, irreversible dementias as well as mental retardation) which has resulted in functional impairment which subsequently interferes with or limits one or more major life activities.
>
> 'Functional Impairment' addresses the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health - illness and is viewed from the individual's perspective within his environmental context. Functional impairment is defined as difficulties that

substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety."

Developmental Services

Developmental Services actual expenditures in FY02 were $60,727,734 with 393.5 positions funded. This compares with $53,838,066 during FY01, a 12.8% increase. Positions declined from 404 in FY01, a decrease of 10.5 positions as the state run institutions were downsized and services moved to the community.

Three regional centers provide services for people with developmental disabilities and related conditions throughout Nevada. In the Las Vegas area, Desert Regional Center offers community-based services in it's main office and three branch offices in Henderson, Pahrump and North Las Vegas. The largest state–run residential treatment program is located on the campus near the main office. In the Reno area, Sierra Regional Center provides community-based services and is the location of the other state-run residential treatment program in the state. Rural Regional Center, located in Carson City with satellite offices in Elko, Fallon, Silver Springs and Winnemucca, offers community-based services for the rural Nevada counties.

These facilities provide a full range of services for people with developmental disabilities and related conditions and their families that include: Service Coordination, Family Support (respite, financial and other assistance), Jobs and Day Training, Residential Programs, and Quality Assurance. In Fiscal Year 2002, these programs served 3153 individuals.

The service vision for the Division's developmental services programs, "Developmental Services Vision for the year 2000", was developed based on stakeholder input in 1997.

The Division also seeks "to assure that individuals with developmental disabilities and their families have access to culturally competent services, supports and other assistance and opportunities that promote independence, productivity, and integration and inclusion into the community (The Developmental Disabilities Assistance and Bill of Rights Act Amendments of 2000)."

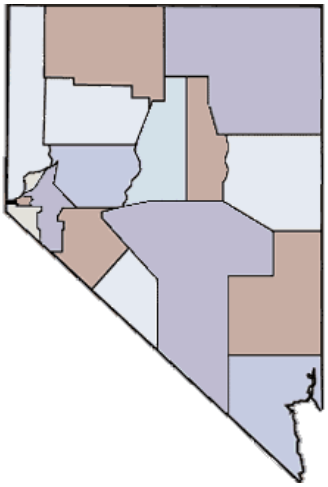
The service priority within the Division for developmental services has been to increase community-based living and work options and to reduce the need for people with developmental disabilities to be admitted to state institutions and congregate living facilities.

The number of people living in large state institutional centers has been decreasing over several years. This is due to the reduction of state run beds and focus on community and family supports for all new services.

DESERT REGIONAL CENTER

RURAL REGIONAL CENTER

SIERRA REGIONAL CENTER



SERVICE LOCATIONS

MENTAL HEALTH & DEVELOPMENTAL SERVICES (MHDS)
505 East King Street, Room 602
Carson City, Nevada 89701-3790
Telephone (775) 684-5943
Faxes (775) 687-5966 & 687-5964
E-Mail: mhds@govmail.state.nv.us
Carlos Brandenburg, Ph.D., Administrator
Debbie Hosselkus, LSW, Deputy Administrator
David Rosin M.D., State Medical Director

SIERRA REGIONAL CENTER (SRC)
Family Support Programs
605 South 21st Street
Sparks, Nevada 89431-5599
Telephone (775) 688-1930
Fax (775) 688-1947
Dave Luke, Ph.D., Associate Administrator
For Developmental Services

DESERT REGIONAL CENTER (DRC)

1391 South Jones Boulevard
Las Vegas, Nevada 89146-1200
Telephone (702) 486-6200
Fax (702) 486-6334
Stan Dodd, LCSW, Clinic Director

RURAL REGIONAL CENTER (RRC)
625 Fairview Street, Suite 120
Carson City, Nevada 89701-5430
Telephone (775) 687-5162
Fax (775) 687-1001
Marcia Bennett, Ph.D., Clinic Director

LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER

500 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-1900
Fax (775) 688-1909
Elizabeth Neighbors, Ph.D., Director

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)
480 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-2001
Fax (775) 688-2092
Harold Cook, Ph.D., Clinic Director

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)
6161 West Charleston Boulevard
Las Vegas, Nevada 89146-1126
Telephone (702) 486-6000
Fax (702) 486-6248
Jonna Triggs, Ed.D., Clinic Director

SNAMHS - North Las Vegas Office
2121 North Las Vegas Boulevard
North Las Vegas, Nevada 89030
Telephone (702) 486-5750
Fax (702) 486-5769

SNAMHS - Henderson Office
98 East Lake Mead Drive
Henderson, Nevada 89015
Telephone (702) 486-6700
Fax (702) 486-6708

SNAMHS - Southeast Office
1820 East Sahara Avenue,
Suite 109
Las Vegas, Nevada 89104-3736
Telephone (702) 486-8289
Fax (702) 486-8295

SERVICE LOCATIONS

RURAL CLINICS: Administrative Office
503 North Division St.
Carson City, NV 89703-4104
Telephone (775) 687-1000; Fax (775) 687-3544
Larry Buel, Ph.D., Clinic Director

RURAL CLINICS:

Battle Mountain Mental Health Center
101 Carson Road, Suite #1/P.O. Box 50
Battle Mountain, NV 89820-0050
(775) 635-5753; (775) 635-8028 Fax
David Dummar, MFT

Carson Mental Health Center
1330 South Curry Street
Carson City, NV 89703-5202
(775) 687-4195; (775) 687-5103 Fax
Sueann Bawden MFT, Clinic Director

Dayton Mental Health Center
120 Pike Street/P.O. Box 1597
Dayton, NV 89403-1597
(775) 246-5240; (775) 246-5364 Fax
Marilyn Newell MA, Clinic Director

Douglas Mental Health Center
1538 HWY 395 N, Gardnerville, NV 89401-5239
(P.O.Box 1509, Minden, NV 89423-1509)
(775) 782-3671; (775) 782-6639 Fax
Tom Embree Ph.D.,MFT, Clinic Director

Elko Mental Health Center
1515 7th Street
Elko, NV 89801-2558
(775) 738-8021; (775) 738-8842 Fax
Jeanne Carey, MSW, Clinic Director

Ely Mental Health Center
1665 Avenue F/P.O. Box 151107
Ely, NV 89315
(775) 289-1671; (775) 289-1699 Fax
Patty Hill, LCSW, Clinic Director

Fallon Mental Health Center
151 North Main Street
Fallon, NV 89406-2909
(775) 423-7141; (775) 423-4020 Fax
Dolly Coke, LCSW, Clinic Director

Fernley Mental Health Center
115 West Main Street/P.O. Box 2314
Fernley, NV 89408-2314
(775) 575-0670; (775) 575-0672 Fax
Marilyn Newell MA., Clinic Director

Hawthorne Mental Health Center
1000 "C" Street/P. O. Box 12
Hawthorne, NV 89415-0012
(775) 945-3387; (775) 945-2307 Fax
Dolly Coke, LCSW, Ph.D., Clinic Director

Lovelock Mental Health Center
775 Cornell Ave. Suite #C/P.O. Box 1046
Lovelock, NV 89419-1046
(775) 273-1036; (775) 273-1109 Fax
Sharon Maginnis, MFT, MH Counselor III

Mesquite Mental Health Center
61 N Willow Suite 4 /P.O. Box 3567
Mesquite, NV 89024
(702) 346-4696; (702) 346-4699 Fax
Kathleen Pantaze, LCSW,LADC, Clinic Director

Pahrump Mental Health Center
1840 South Pahrump Valley Blvd. Suite A
Pahrump, NV 89048
(775) 751-7406; (775) 751-7409 Fax
Kathleen Settle, MSSA., Clinic Director

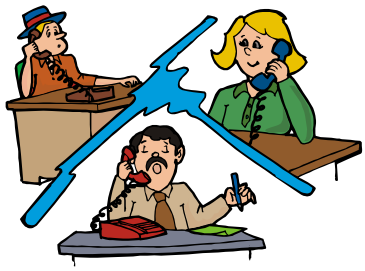
Silver Springs Mental Health Center
3595 Highway 50 East/P.O. Box 1136
Springs, NV 89429-1136
(775) 577-0319; (775) 577-9571 Fax
Marilyn Newell MA., Clinic Director

Tonopah Mental Health Center
825 S Main P.O. Box 494
Tonopah, NV 89049-0494
(775) 482-6742 & 482-9819 Emergency
(775) 482-3718 Fax;
Kathleen Settle, MSSA, Clinic Director

Winnemucca Mental Health Center
3140 Traders Way/P.O. Box 230
Winnemucca, NV 89446-0230
(775) 623-6580; (775) 623-6584 Fax
David Dummar, LMFT, Clinic Director

Yerington Mental Health Center
310 Surprise Avenue
Yerington, NV 89447-2542
(775) 463-3191; (775) 463-4641 Fax
Marilyn Newell MA, Clinic Director

STAKEHOLDERS



Stakeholder Values

Community Integration:
Consumers contribute to the community through positive behavior.

Consumer Involvement:
Consumers are educated about their disorders and actively involved in their treatment.

Consumer Satisfaction:
Consumers feel good about the kinds of services received.

Family Support:
Consumers' families are informed and involved.

Safety:
Consumers and the community are safe from the consumers behavior.

MHDS-MENTAL HEALTH SERVICES:

Involving Stakeholders in Planning and Evaluation

MHDS directly involves its stakeholders in the planning and quality improvement of its mental health programs. Consumers, family members, legislators, and mental health professionals, as well as representatives from the courts and correctional fields, have been formally involved in the definition of values that underlie the mission of the Division and guide the strategic planning of the mental health programs. The general community is also invited to participate in strategic planning meetings, and has been instrumental in defining the mission statements of the agencies. These stakeholders are regularly updated on the progress made toward the goals and objectives of the Division.

MHDS is excited to report that great strides have been made over the past two years in our efforts to involve consumers in the delivery of our programs. Since our last report in 2000, we have worked to ensure that consumers are active in each region. We have promoted consumer representation at most local advisory board meetings and the meetings of the Commission on Mental Health and Developmental Services, which is the statutorily authorized governing body in Nevada.

A primary way we have strengthened the involvement of consumers is by our increasing collaboration with the Nevada Mental Health Planning Advisory Council (MHPAC). The Council is a 17-member group established in 1989 with the goal of serving as an advocate for chronically mentally ill individuals, severely emotionally disturbed children and youth, and other individuals with mental illnesses or emotional problems. By federal mandate, greater than 50% of the members of the Council must be non-State representatives that include consumers of mental health services, family members, and other mental health advocates. The MHPAC works with the Division in a variety of ways, all of which are designed to involve consumers in the development and delivery of mental health services here in Nevada. Major activities of MHPAC include the following:

- The Council advises the Division of Mental Health and Developmental Services and the Division of Child and Family Services on the development of the State Mental Health Plan.
- The Council serves as an advocate for adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and others with mental illnesses and emotional problems.

- The Council reviews and assists with the administration of the Center for Mental Health Services (CMHS) Block Grant, which helps fund Nevada's community-based system of care.
- The Council develops education and training opportunities for consumers of mental health services and family members of consumers.
- The Council promotes awareness of mental health issues within the State, and works to positively influence the State Legislature regarding laws and budget decisions that affect consumers of mental health services.

During the last two years, the MHPAC has worked to implement an innovative new program to increase consumer involvement by directly awarding funds from the MHPAC administrative budget for consumer services. These awards total between $30,000 and $50,000 per year and are focused the following:

1. Community-based services that benefit consumers directly
2. Consumer education and training
3. Professional education and training on mental health issues

By directly funding consumer services, in 2001 the Council began to support grass-roots efforts within the state to provide services to consumers and to educate the professionals who work with consumers. The Council has partnered with both MHDS and other nonprofit organizations to provide the services and information needed to improve the quality of mental health care provided to children and adults in Nevada.

Three projects were funded by the MHPAC in 2002 for the upcoming fiscal year. One is the Nevada Recovery Guide, which is a Website that provides recovery-related resources via that Internet that includes information for mental health and recovery professionals, community service organizations, and consumers who are seeking help with a mental health or substance abuse issue. Another is the Northern Nevada Adult Mental Health Services (NNAMHS) Canteen Employment Learning Lab. This project is designed to provide consumers training in work skills, interpersonal communication, team building, basics of food service, work habits, time management, organizational skills, and customer service. The third project is the Mental Health Association (MHA) of Southern Nevada Leadership Academy Training. This training is designed for consumers to increase their well-being, their self esteem, their capabilities for self-determination, their share in the direction of the mental health system, and their understanding and incentive to contribute their skills and concern to the betterment of the larger community.

Since our last report in 2000, we are excited and proud to report that now, more than ever before, the MHPAC is dynamic, energized, and actively engaged in our programs.

CONSUMERS

Consumer feedback is greatly valued.

Opportunities for consumer feedback include:

- Inpatient consumer survey conducted with each consumer prior to discharge from the hospital.
- Outpatient consumer survey conducted with consumers in community based programs.
- Consumer comment forms and boxes allow consumers to comment anonymously about the services that they receive at any time they wish.

CONSUMERS

MHDS Strategic Plan Goal #3:

Ensure that services address the interests, rights, and needs of each individual consumer served.

Stakeholder Values

Improved Social Functioning: Consumers make progress in work, school and relationships.

Personhood: Consumers have worth and dignity.

Skilled Coping: Consumers gain skills needed to handle the problems of life.

Symptom Reduction: Consumers symptoms are reduced, stabilized or prevented.

Over the past two years we have also made great strides to facilitate the collaboration of policy making and advisory bodies here in Nevada. To illustrate, in February, 2002, the Council met with the Nevada Commission on Mental Health and Developmental Services, which marked the first time these two primary planning and governance bodies have ever met or worked together. These initial meetings were quite successful and both bodies began collaborative legislative planning to better the provision of mental health services in Nevada. We hope to continue this endeavor in 2003.

Another great new way MHDS began to involve mental health consumers is via an exciting new program that began in 2002 called the Consumer Assistance Program (CAP).

Since the mid 1990's, the Nevada Division of Mental Health and Developmental Services (MHDS) has been interested in hiring consumers as part of transitional mental health services. Nevada's new Consumer Assistance Program began this year (2002), and is designed to assist other consumers as they become involved in the treatment process, as well as help Division personnel work more effectively with mentally ill adults.

We are pleased that we can report here that Nevada's first-ever Statewide CAP Coordinator began service as an MHDS employee in June 2002, and quickly hired the staff of six consumers as part of the new Consumer Assistance Program. During 2002, MHDS was able to set annual federal funding for this program at approximately $270,000 per federal fiscal year. With these funds, MHDS positioned seven full-time employees (FTE) across the state as part of the CAP:

- ✓ Three FTE Consumer Services Assistants at Southern Nevada Adult Mental Health Services (SNAMHS); one is the Statewide CAP Coordinator.

- ✓ Two FTE Consumer Services Assistants at Northern Nevada Adult Mental Health services (NNAMHS).

- ✓ Two FTE Consumer Services Assistants at Rural Clinics, one each in Minden and Carson City clinics.

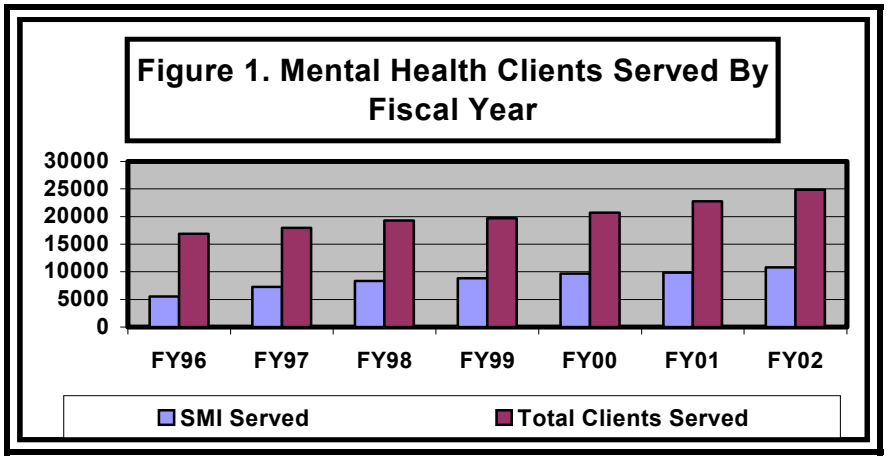
The Consumer Assistance Program employs seven FTE and is designed so that our own consumers can work with other consumers in our system to develop work and career transitional skills. Our Consumer Assistants also mentor recently discharged consumers, and collect consumer surveys, as well as assist the Division in quality assurance efforts, and designing statewide consumer advocacy and policy development efforts. Our Consumer Assistants also work to make sure our website is as user friendly as we can make it. They develop statewide consumer flyers and social events. They also participate in various human rights boards, and review all consumer care complaints. Finally, we are pleased that our new Consumer Assistance positions were designed to afford these individuals promotional career opportunities into other permanent State positions.

We are optimistic that our existing Consumer Assistance Program is in the early stage of development, and we can report in our next biennial report that we will have added additional Consumer Assistants and further expanded this program.

Who are the Recipients of Mental Health Services?

The Division of Mental Health and Developmental Services directly provides or coordinates the provision of contracted adult public mental health services in Nevada. MHDS Rural Clinics also provide services to children and families. A University affiliated provider, Mojave Adult, Child and Family Services in Las Vegas provides much of the regions outpatient services through referral from SNAMHS. Inpatient and outpatient programs are provided primarily on a fee for service basis since people with serious mental illness have been "carved out" of the State's managed care structure.

The Center for Mental Health Services[1] estimates that 7.2% of the population in Nevada will suffer from a severe mental illness during their life. More recently, a study [2] ranked Nevada as the number one state in the Western United States for prevalence of mental illness, estimating that as much as 23.7% of the population in Nevada will have some form of diagnosable mental disorder during their life. It also estimated that approximately 1.8% of Nevadans are currently functionally impaired because of a serious mental illness. In FY 2002, the Division's mental health programs served 22,341 people. This is an increase of 9% over last year. **Figure 1** shows the growth in individuals served over the last seven fiscal years. **Table 1** shows the breakdown by agency for FY01 and FY02. You can see that Rural Clinics caseload is down. This is because the agency is unable to recruit positions for the rural area. **Figure 2** shows percent of consumers by agency.



1 *Estimation of the 12-Month Prevalence of Serious Mental Illness*, CMHS Draft, Kessler, et al. 1997.
2 *Needs Assessment in the West: a Report on a Workshop and Subsequent Analysis* (WSDSG, 1998)

CONSUMERS

MHDS Strategic Plan Goal #4:

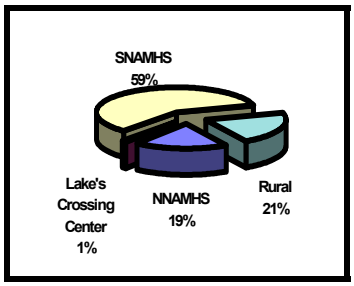
Utilize technology to improve accessibility to, and availability of services and the efficient use of resources.

MHDS Strategic Plan Goal #5:

Update and maintain a plan to respond to emergencies in Nevada in a timely and effective manner.

MENTAL HEALTH CONSUMERS

Figure 2. Percent of Total Clients Served by Agency



President George W. Bush announced the creation of The President's New Freedom Commission on Mental Health at the University of New Mexico in Albuquerque on April 29, 2002. In his address, the President stated that "our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care."

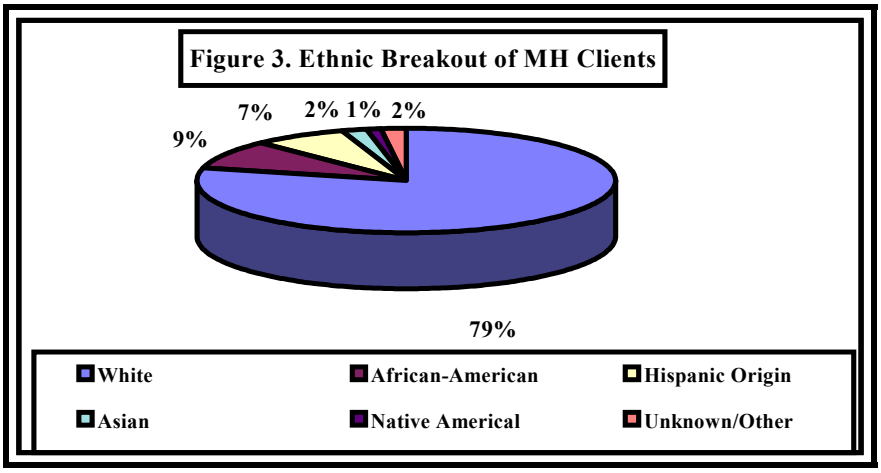
Table 1. Unduplicated Clients Served: Percent Growth

	FY01	FY02	%change
Lakes	173	191	10%
NNAMHS	4022	4485	12%
SNAMHS	11528	12996	13%
Rural Clinics	4852	4669	-4%
TOTAL	20575	22341	9%

With the exception of MHDS' forensic facility, the state demography shows an equal split between male and female and MH shows a consumer ratio of 56% female to 44% male. Around 67 percent of the consumers served by SNAMHS and 47% of Rural Clinics' consumers are between 21 and 44 years of age. MHDS only serves children through its Rural Clinics, where they comprise 30% of the client base. The demographers estimate for the percentage of children in the state is 18.4%.

Approximately one third of the consumers have never married, and most claim only themselves as a single dependent. More than one third are unemployed.

Approximately 79% of MHDS' consumers are white which is comparable to Nevada's population figure of 69% projected for FY02. **Figure 3**, details MHDS' breakout of clients by ethnicity. The largest category of racial minorities served at Nevada's urban mental health centers are African Americans. In contrast, Native Americans are the

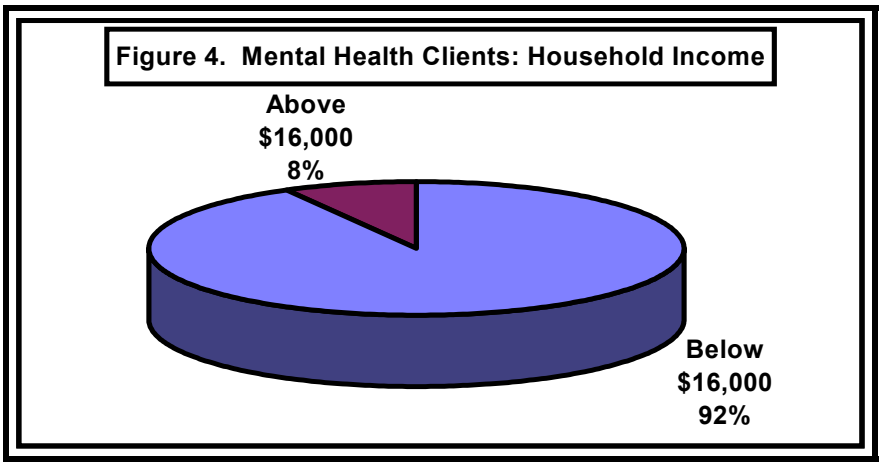


Note, although included, Hispanics are an ethnicity, not a race. MHDS Rural data included in breakout comparison.

3. Division Demographics are based on FY2002 data analysis .

primary racial minority in MHDS rural mental health clinics. Ethnically, approximately 7% of the State's public mental health consumers are Hispanic. The state demographer estimates that Hispanics (Hispanic Origin of any race) will comprise around 19% of Nevada's population by 2003.

It is estimated that in 2002, 10.3% of all Nevadans lived below the poverty level. This contrasts sharply with the consumers of Nevada's public mental health services. As a rule, the people who come for mental health service are from lower income brackets, with approximately 92% of MHDS' consumers earning below the $16,000 per year. **Figure 4** shows percent of clients below $16,000 in income. In 1999 7.5% of Nevada families were below the poverty level.



Note: This data excludes the unknown category

Generally, people come to MHDS' locations for treatment of a few primary disorders: major depression, psychosis, bipolar or schizophrenic episodes. Outpatient consumers show a wider range of treatment needs. Seventy six percent of outpatient clients fall into several categories: adjustment disorders, mood disorders, major depression, dysthymia, and schizophrenia. Around 10% of our outpatient consumers have a dual diagnosis, suffering from both mental illness and substance abuse.

The 750 children who were served by the Division's Rural Clinics primarily sought service in FY 00 for help with depression (10.8%), attention deficit (33%), bipolar (3.3%) adjustment disorder (31.8%), and anxiety (6.9%).

MENTAL HEALTH SERVICES

Top Outpatient Diagnosis at Admission (FY00)

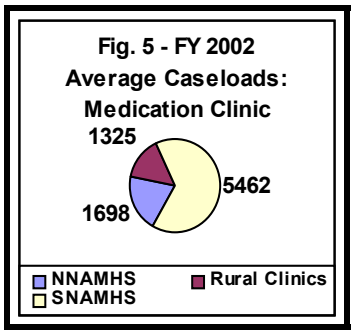
Mood Disorders	49%
Schizophrenia and related	17%
Substance Related Disorders	10%
Adjustment & Personality Disorders	7%
Other Disorders	20%

Top Inpatient Diagnosis at Admission (FY00)

Schizophrenia and related	43%
Mood Disorders	35%
Substance Related Disorders	10%
Adjustment & Personality Disorders	7%
Other Disorders	5%

MENTAL HEALTH PROGRAMS

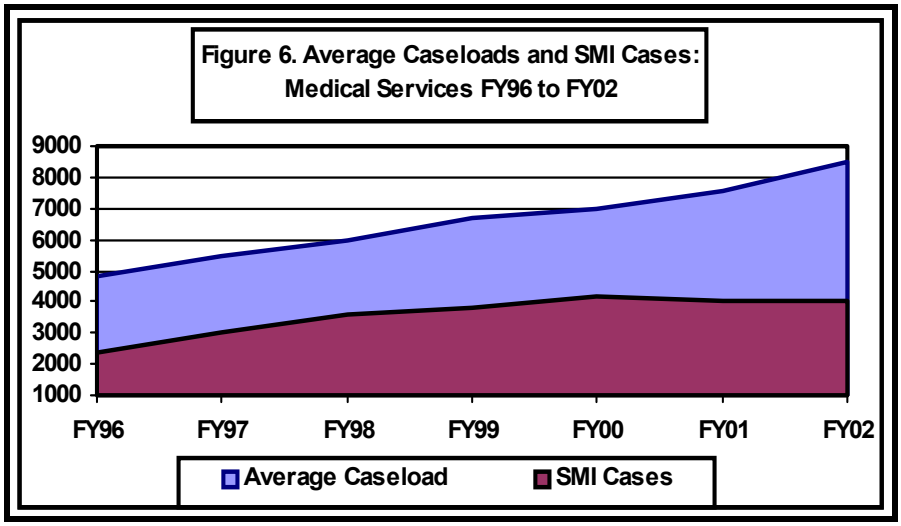
MEDICATION CLINIC



Several levels of mental health care are provided through inpatient and outpatient programs. Consumers requiring intensive care are supported by inpatient services and intensive outpatient programs. Other outpatient programs help the consumer gain greater independence, confidence and ability to function in the community.

The Role of New Medications: The Division's medical services are provided by a physician or advanced practice nurse with prescriptive privileges to evaluate, prescribe and monitor medications for the treatment of psychiatric disorders. Services may also include pharmaceutical counseling and education provided by a pharmacist. Since medication forms a foundation of treating most mental illnesses, the medication clinic is the Division's largest treatment program (**Figure 5** shows the medical services consumer served by agency. **Figure 6** shows program growth). Medication costs account for $11,157,803 or 15.70% of the FY02 Mental Health budget.

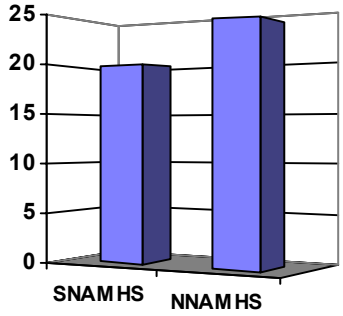
Newer antidepressant and anti-psychotic medications have had fewer negative side effects than older medications. While they cost more, they benefit consumer functioning and reduce the demand



and duration of other expensive treatment forms. The Division has increased funding for these new medications so the consumers can have access to these medications.

INPATIENT SERVICES

Figure 7 - Average Length of Stay in Days (FY 2002)



Inpatient Programs:

Inpatient facilities at the Northern Nevada Adult Mental Health Services (Dini-Townsend Hospital) and Southern Nevada Adult Mental Health Services (Muril H. Stein Hospital) focus on con-

sumer recovery and stabilization.
For example, at SNAMHS, individuals in crisis are served by an outpatient program Psychiatric Emergency Services (PES) which has a Psychiatric Ambulatory Unit, providing 24 hour emergency walk-in center service for clients in crisis and a Psychiatric Observation Unit (POU), a 72 hour observation unit for consumers needing short term observation, stabilization and treatment in a secure environment. The POU currently has a capacity for 20 patients. The provision of psychiatric emergency services (PES) allows consumers in crisis to be stabilized and avoid admission to the hospital. The positive effect of this program is shown by the fact that more than 82% of the consumers admitted to the SNAMHS POU are stabilized and avoid hospitalization.

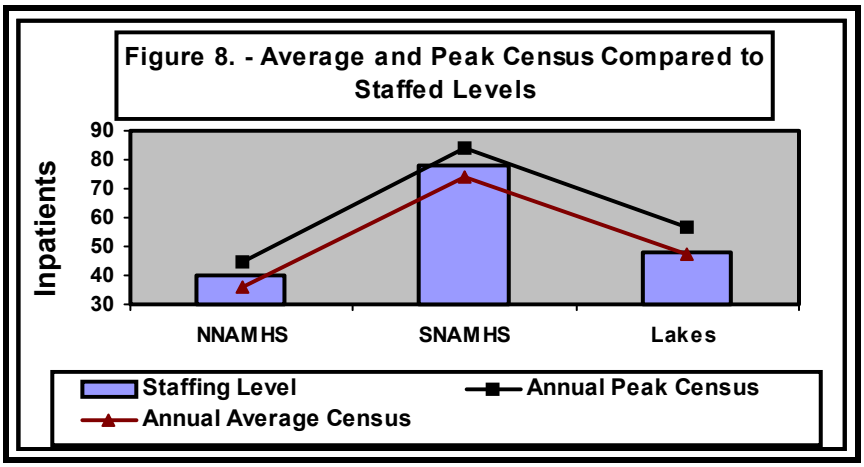
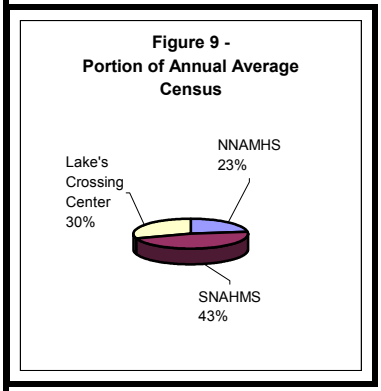


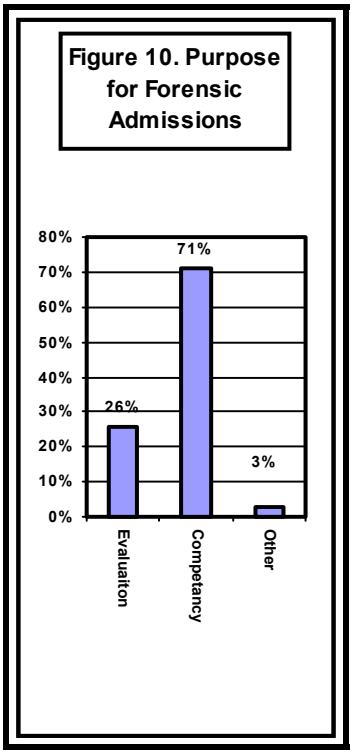
Figure 7 (previous page – sidebar) compares the average length of stay between SNAMHS and NNAMHS for inpatient. **Figure 8** compares the average census and peak census for each of the mental health inpatient facilities in Fiscal Year 2002. **Figure 9** (sidebar) shows the portion of inpatient consumers served at each of the hospitals.

Forensic Services: Lake's Crossing Center was designed to serve the mentally disordered criminal offender, to evaluate competency to stand trial, assess criminal responsibility and/or provide recommendations for treatment. Services include clinical assessment, forensic evaluation and short or long term treatment as appropriate based on the nature of the court commitment. Ninety seven percent (97%) of the consumers are sent to the Center by the courts for treatment to establish competency to stand trial or for initial competency evaluations (see **Figure 10** – sidebar). This relationship between this agency and the court and legal system is defined in NRS Chapter 178. The 48 bed Center served 203 consumers in Fiscal Year 2000. Eighty seven percent (87%) of all admitted clients in FY 2000 were Nevada residents; Thirteen percent (13%) were from California and other states. Most of the state admissions come from urban areas (12% north, 65% south) with only 23% admitted from rural Nevada. As an average in FY 2000, client length of stay is 112 days. During Fiscal Year 2000, the census peaked above facility capacity four months out of the year. The highest peak was 23% above capacity.

INPATIENT SERVICES



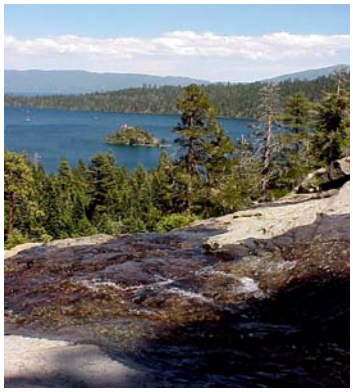
FORENSIC SERVICES



PROGRAMS AND SERVICES

PACT

The Program for Assertive Community Treatment uses a multidisciplinary mental health team to provide customized mental health services.



ISC

Intensive service coordination provides more intensive care for forensic consumers in Southern Nevada

Outpatient Programs with an Intensive Care Focus:

Program for Assertive Community Treatment (PACT): This program provides intensive community based treatment and rehabilitation services to consumers with serious mental illness by using a multidisciplinary mental health team to provide these services. The goal of the program is to reduce debilitating symptoms and minimize or prevent recurrent acute episodes of illness. Continuous rather than time limited service and interventions tailored to each consumer characterize this program. Nationally, the PACT model has shown participants to have longer and more productive community tenure and be better able to manage their impairment upon discharge from the program.

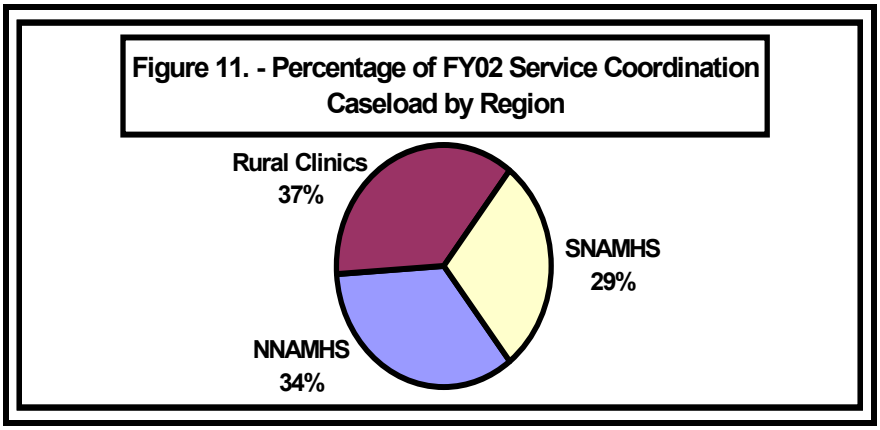
This program started serving clients at Southern Nevada Adult Mental Health Services campus in March 1998. The program had a caseload of 73 consumers in the program June 2002 and has been undergoing planned growth of around 5 new consumers per month. For comparison; in Fiscal Year 1998 the program was serving 23 consumers. Northern Nevada Adult Mental Health Services began this program in Fiscal Year 1999.

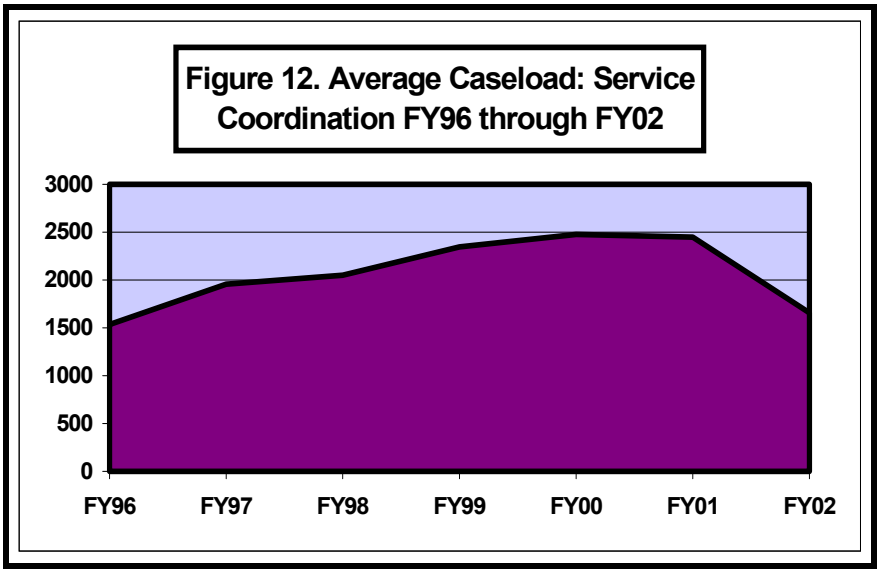
Intensive Service Coordination: Intensive service coordination provides more intensive care for forensic consumers in Southern Nevada. This growing number of people tends to have numerous and long term hospital stays as well as extended time in jails and/or prison. Each day a patient is in the hospital ($389/day) or jail/prison (approximately $90/day) is extremely costly for the state. These patients need intensive assistance to develop independent living skills, medication compliance, social skills, employment skills, and anger management processes to reduce or eliminate violent or criminal behaviors. The goal of ISC is to assist the consumer in achieving and maintaining the highest level of independent functioning possible, while reducing time spent in either the hospital or in jail/prison. The program began serving consumers at SNAMHS in December 1997. Since that time, the average monthly caseload has more than quadrupled, growing from 11 initial consumers to 49 consumers at the end of Fiscal Year 2002. The program is budgeted to support a caseload of 45 people.

Outpatient programs focusing on increasing consumer independence:

Service Coordination : Service Coordinators coordinate treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan developed with the client. They assure that consumers access financial, housing, medical, employment, social, transportation, crisis intervention, entitlement and other essential community resources. They also help mobilize family, community, and self-help groups on the consumer's behalf. They may provide direct treatment to consumers when none is avail-

able through referrals or community agencies. MHDS' Service Coordination caseload averaged around 571 cases at NNAMHS, 609 cases at Rural Clinics and 478 cases at SNAMHS. Additionally, Mojave Adult, Child and Family Services (University affiliated provider under contract to MHDS) served an average monthly caseload of 696 people. (**Figure 11** shows service coordination case distribution, **Figure 12** – caseload over last seven years).[4]





4 This does not include clients at Mojave Adult, Child and Family Service

Outpatient Counseling: Outpatient counseling services provided to individuals include diagnosis and evaluation, counseling, psychotherapy, and behavioral management. These programs focus on developing insight, producing cognitive/behavioral change, improving decision-making, and/or reducing stress. Specialized services are provided to families and couples to facilitate communication between patients and family members. Group counseling sessions include activity therapy as well as psychotherapy to help guide consumers through

Personal Service Coordination

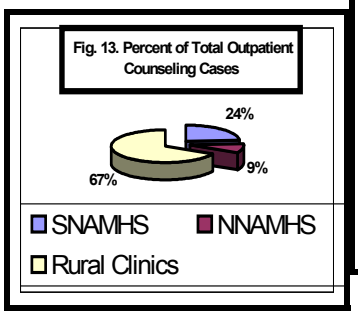
There are many models of community care for persons with mental illness.

The Division policy 3.002 defines this service as:

- *Arrange access to needed service.*
- *Assure efficient and timely coordination of services.*
- *Maximize the client's capacity to benefit from services and to function independently.*
- *Limit unnecessary restrictive treatment.*
- *Mobilize the support of family, friends and advocates.*

OUTPATIENT SERVICES

Outpatient Counseling



interpersonal conflict and improve positive communication. Outpatient Counseling, Rural Clinic's primary program, serves as the foundation program for all of its consumers. NNAMHS and SNAMHS may admit consumers into other programs, such as service coordination, without first seeing a counselor. **Figure 13**-(side-bar) shows the portion of outpatient counseling consumers served by agency. **Figure 14** shows 7 years of counseling caseloads.

Psychosocial Rehabilitation and Vocational Programs:

Psychosocial rehabilitation is targeted to consumers in need of an active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of functioning in the community and to prevent acute inpatient care. Emphasis is placed on acquiring skills in the following areas: survival and adaptation, symptom and medication management, problem solving, grooming, financial management, prevocational services, and management of leisure time. Programs are individualized for the con-

Figure 14. Outpatient Counseling: Average Caseloads by Agency

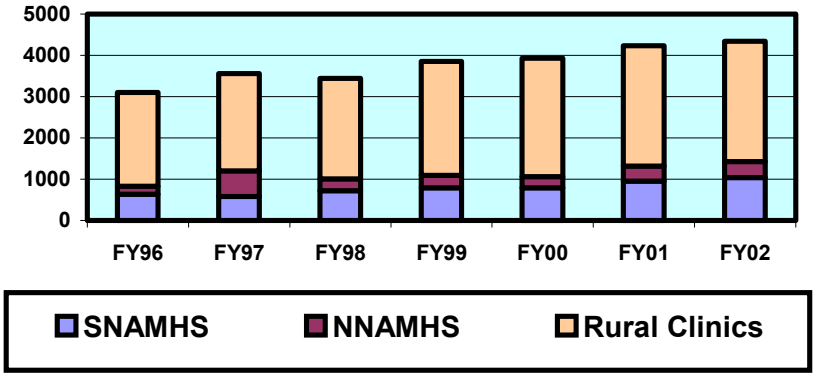
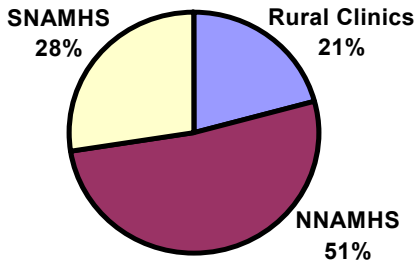
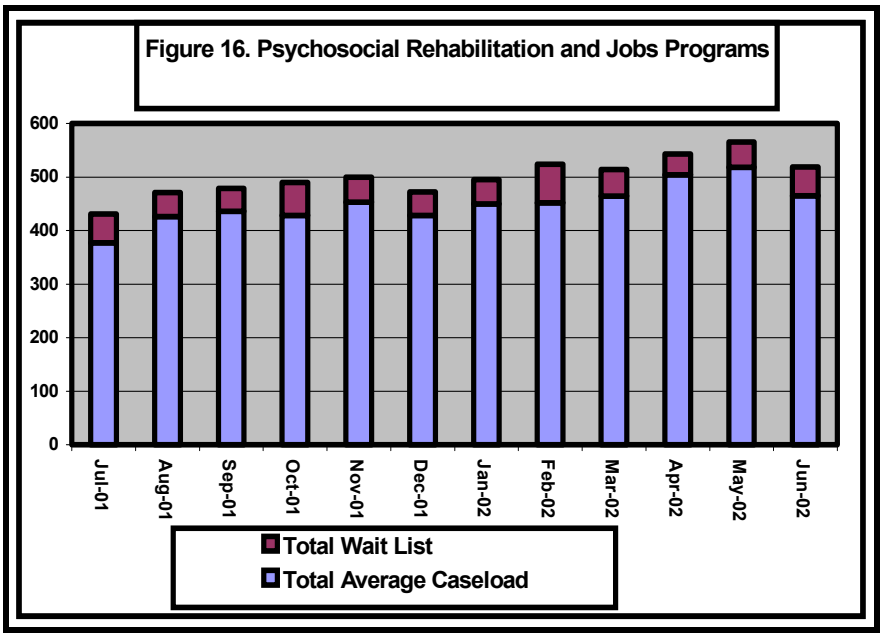


Figure 15. - Psychosocial Rehabilitation/Jobs: Percent of Average Monthly Caseload



sumers. Some services are provided under contract and may take place in a classroom setting or at the consumer's residence. **Figure 15** (previous page) shows each agency's portion of the psychosocial rehabilitation caseload. **Figure 16** shows program caseload and wait list during Fiscal Year 2002.

Vocational programs include vocational guidance and counseling, and transitional planning. They also provide an array of skills training through school, peer advocacy, world of work classes through BVR and on the job training and apprenticeships. This program assists with job seeking skills and provides support during job seeking as well as thru the State's Bureau of Vocational Rehabilitation (BVR). Consumers are assisted through vocational assessment, work adjustment training and post-employment services designed to maintain employment by focusing on decision making, problem solving and establishing natural community supports. Additionally, joint efforts between MHDS and the BVR provide collaborative assistance to help consumers achieve their vocational goals.



These programs are in demand by consumers as can be seen by their waiting lists for services (**Figure 17**). The Divisional annual average caseload (Vocational and Psychosocial Rehabilitation programs combined) in Fiscal Year 2002 was at 450 clients .

Residential Supports:

Group housing: These are group residential programs for clients who do not require specialized intensive services. The Division average annual caseload is approximately 457 clients (see **Figure 18** (following page).

Supported Living Arrangements (SLAs): These living arrangements are intended to be flexible and offer housing based on consumer choice and individualized services tailored to the consumer's needs so that services have a "wrap around" effect and encompass the capabilities of the consumer. Consumers, families and

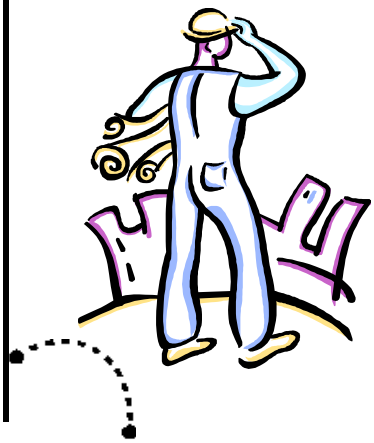
Psychosocial Rehabilitation And Jobs

Peer counselors, themselves prior consumers of the mental health system, work with clients in these programs by providing education, advocacy, and support.

OUTPATIENT SERVICES

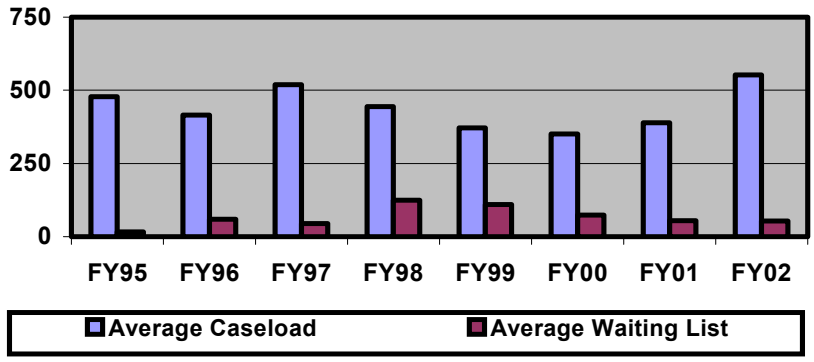
Helping people find employment through vocational assistance and training

A key ingredient of recovery-based services includes encouraging consumers to think about the future. There are such considerations as meaningful work activities (including volunteer activities).



agencies collaborate in the development of a plan that will place the client in an independent setting. The program includes purchased community SLA's, contract services and the HUD Shelter Plus Care program for homeless mentally ill people. **Figure 18** compares the seven year average group housing caseloads to the average number of SLA contracts.

Figure 17. Mental Health Vocational and Psychosocial Rehabilitation Caseloads and Waiting Lists



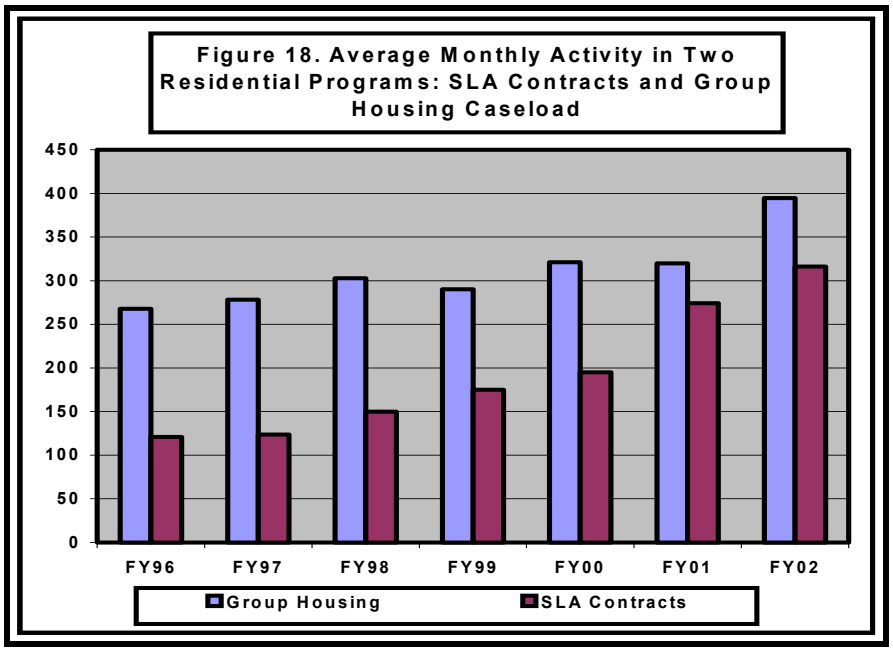
Specialized Residential - These programs provide support and/or skills training for residents with specialized service needs who also need psychiatric services. These programs include arrangements that are specially designed to meet the needs of the following individuals: people with medical problems, senior citizens requiring assistance, consumers with severe behavioral symptoms, and deaf consumers, as well as people needing treatment for substance abuse.

Intensive supportive living arrangements (ISLAs) - They provide 24-hour awake supervision of clients who otherwise would require inpatient hospital care. These services are provided in independent apartment community settings with additional individualized support services based on client needs and choice.

Special Needs Beds—They provide independent apartment community settings for medically compromised mentally ill clients who require additional nursing supervision. These placements provide service to clients who otherwise would have remained in the inpatient psychiatric hospital only because self care of their medical condition is compromised by mental illness.

Programs for special populations:

Geriatric Services: These services are supported through grants from the Division of Aging Services and the Bureau of Alcohol and Drug Abuse to the Southern Nevada Adult Mental Health Services. People are referred by the Division of Aging Services.



Homeless services – The Division of MHDS receives funding for programs specifically targeted for those people who are homeless and have a serious mental illness. They are:

- PATH – Projects for Assistance in Transition from Homelessness – A McKinney-Vento Act grant that provides for $300,000 that is in turn contracted to such non-profit agencies as Friends in Service Helping (FISH – Carson City), ReStart (Washoe County) and The Salvation Army (Clark County and Pahrump). Services that are provided with this money range from outreach to mental health services up to and including security deposits/rental assistance

- Shelter Plus Care – A grant from Housing and Urban Development (HUD) has provided approximately $4.5 million in tenant-based rental assistance funding to Division agencies since 1995. The grant is matched in aggregate by Division agencies with supportive services for those persons who are eligible (homeless and have a serious mental illness or other long-duration disability).

- HOPE -- Homelessness Outreach Pilot Evaluation. The Hope Project serves 100 homeless persons with serious mental illnesses and co-occurring substance abuse disorders in metropolitan Las Vegas. It provides a full continuum of substance abuse and addiction treatment services, including a broad array of health and human services, in community-based, residential, and outpatient environments. Utilizing an outreach and case management model of assertive community treatment, it includes rehabilitative, educational and vocational services.

Helping clients achieve greater independence through residential programs

Currently there are approximately 16,049 persons statewide who are homeless and have a serious mental illness.

Housing (safe, decent and affordable) and residential supports play a crucial role in the recovery of persons with mental illness.

FUNDING SOURCES

Mental Health Funding Sources and Expenditures

In fiscal year 2002, MHDS operations cost $136,721,512. In fiscal year 2003 a total of $143,430,495 is budgeted for operations. Of this money the majority (66%), comes from Nevada's state general fund. This is down from 72% in FY2000. Most of the remaining funds are Federal (27%) with revenue from consumers and other sources making up 7% of the total. Only 1.5% of the money is used for central administration. The mental health programs receive 52% of the money, budgeted at $74,959,453 in fiscal year 2003. **Fig. 19** and **Fig. 20** show funding sources and expenditures in Fiscal Year 2002 for Mental Health services.

Figure 19. - FY02 Budget Expenditures

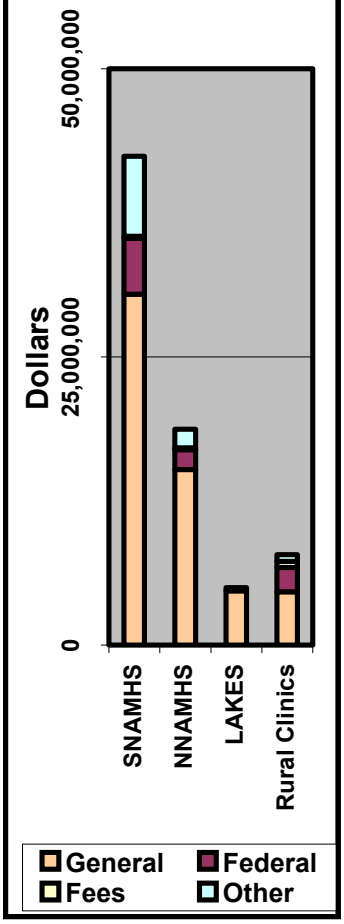
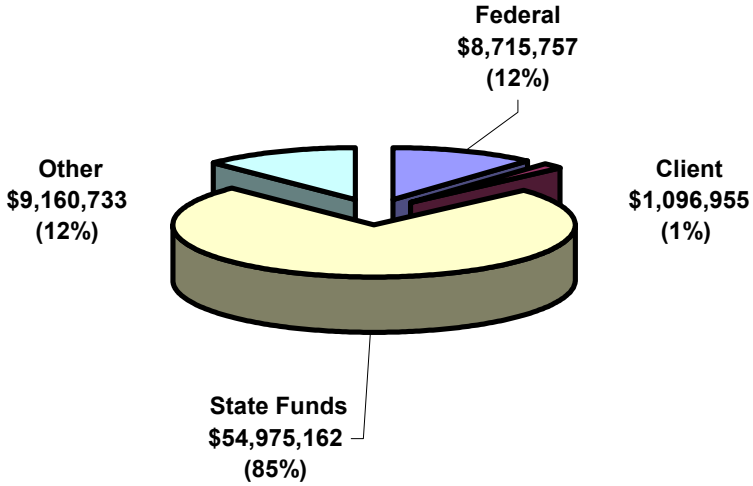


Figure 20. MHDS expenditures Mental Health Funding Sources: Fiscal Year 2002



Staffing to Meet Service Demands

Inpatient facilities are licensed and staffed to support a certain number of client beds. Other programs, such as service coordination (case management) have caseload standards or service level standards. When these are exceeded, waiting lists occur.

The Division was budgeted for 1150 staff positions in fiscal year 2002. Of these, 729 people work for mental health agencies. **Figure 21** shows the distribution of staff in MHDS' mental health agencies. Sixty seven percent of these positions are employed in direct consumers care (see **Figure 22** sidebar). If all programs are combined, there is one direct care staff for every 43 mental health consumer. However, programs differ dramatically in the intensity of service and the staffing required to provide adequate service. The Lake's Crossing Center forensic facility has a ratio of one direct care staff for every 3 consumers. Inpatient facilities at SNAMHS and NNAMHS also have small consumer to staff ratios and serve consumers around the clock. Intensive outpatient services have reduced clinical caseloads, such as one clinician or service coordinator (case manager) for every 15 consumers. Other intensive outpatient services take a team approach to help consumers reduce symptoms and develop self sufficiency. The ability to carry larger clinical or service coordinator caseloads increases as consumers become more independent and services focus more on life management needs than recovery from severe symptoms. Typically, service coordinator caseloads are one service coordinator for every 35 consumers. Many consumers are maintained and function in a stable fashion in the community, only returning for medical services. Thus, nurses providing medical oversight at the medication clinics carry larger caseloads of one nurse to every 217 clients.

Measuring Effectiveness and Performance Indicators in Mental Health Programs

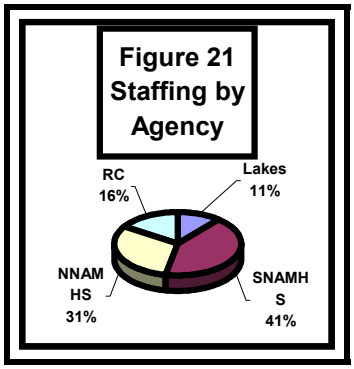
The ability for state public mental health programs to monitor and assure the quality of services through consumer oriented outcomes has been driven from the Federal level through a Presidential Task Force and programs and funding through the Center for Mental Health Services. By participating in organizations such as the National Association of State Mental Health Program Directors, Nevada has shared in this national effort.

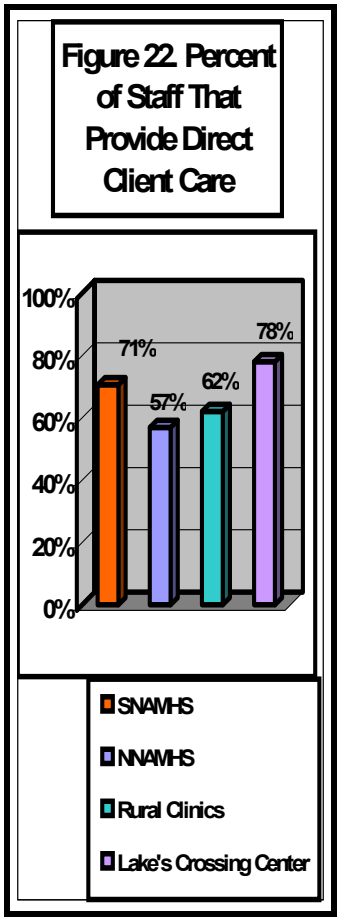
We have received funding from the Center for Mental Health Services through their Data Infrastructure Grant award. The purpose of this grant is to develop and sustain State and community data infrastructure that helps promote comprehensive, community based systems of care for all children and adults with mental illness or at risk of developing mental illness. National standardization of uniform data reporting for the States is a major goal of this grant.

These outcome areas have been further defined in Nevada through a stakeholder values clarification project. Value areas that have been addressed in the development of consumer oriented outcome measures include: Skilled Coping, Personhood, Symptom Reduction, Functioning, Community Integration, Involvement in Treatment, Satisfaction, Family Support and Safety. [5]

STAFFING

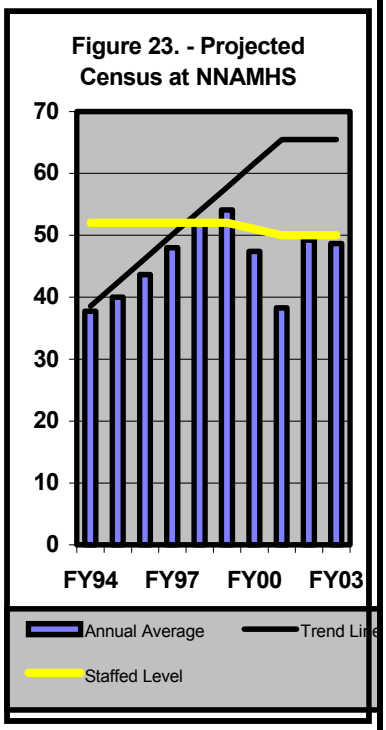
STAFFING PATTERNS





5 *Nevada Stakeholder's Priorities for Mental Health Outcomes*, McGuirk and Zahniser, 1996.

MENTAL HEALTH INDICATORS



Our Quarterly Performance Indicator Report can be viewed on our website for those that want to look at Data for FY02

Http://mhds.state.nv.us

New Mental Health Performance Indicators

The development of new performance measures in Fiscal Year 2002 has allowed MHDS to use more meaningful indicators of service in the Fiscal Year 2002-2003 budget. New annual budget indicators include:

Performance Indicators with definition:

INPATIENT

- Percent of clients in hospital over 90 days. - Current inpatients with LOS > 90 for those discharged.
- 30 Day Readmission Rate. - Rate of readmissions to an inpatient facility that occur within 30 days of a previous discharge from the same facility.

OUTPATIENT COUNSELING

- Wait Time. - Number of days from referral to first scheduled appointment.
- OC-Only Clients admitted to the POU. - Percent of clients open only to OC who were admitted to the POU.

SENIOR MENTAL HEALTH OUTREACH

- Wait Time. - Number of days from referral to first scheduled appointment.
- Average Scale at Intake. - The average score of clients using the Geriatric Depression Scale.
- Average Scale at 3 months. - The average score of clients after 3 months using the Geriatric depression Scale.

SERVICE COORDINATION

- Inpatient Days Before and After Starting Program. - Percent of time clients were in IP before and after starting to receive the program's services.
- Wait Time. - Number of days from referral to first scheduled appointment.

INTENSIVE SERVICE COORDINATION

- Inpatient days Before and After Starting Program. - Percent of time clients were in IP before and after starting to receive program's services.
- Re-offenses. - Number of clients that are jailed because of a felony arrest while in the program.

MEDICATION CLINIC

- Clients Attending Their First Appointment. - Percentage of new clients attending their first scheduled appointment.
- Average Wait Time. - Average number of days from referral to first scheduled appointment.

- Wait Time. - Number of days from referral to first scheduled appointment.
- MC-Only Clients Admitted to the POU. - Percent of clients open to only MC who were admitted to POU.

MEDICATION CLINIC (MC) AND OUTPATIENT COUNSELING (OC)

- MC and OC only clients admitted to the POU. - Percent of clients open only to MC and OC who were admitted to the POU.

GROUP HOUSING

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

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SUPPORTIVE LIVING ARRANGEMENTS

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

INTENSIVE SUPPORTIVE LIVING ARRANGEMENTS

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

RESIDENTIAL TREATMENT PROGRAM

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

PES (Psychological Emergency Services)

- Inpatient Deflections and Admissions. - Percentage of persons receiving PES services who were deflected from IP versus those who were admitted to IP.

PACT (Program For Assertive Community Treatment)

- Inpatient Days Before and After Starting Program. - Percent of time clients were in inpatient before and after starting to receive the program's services.

LAKES CROSSING CENTER

- Evaluation of Competency. -Average length of stay. (Calculated from date of admission to date of discharge).
- Incompetent to stand trial. -average length of evaluation. (Calculated from date of admission to date letter sent to court with findings).
- Competency Determination. - Percent of clients admitted as incompetent to stand trial. (Calculated from date of admission to date letter sent to court with findings).

Figure 23 (on previous page) shows the NNAMHS inpatient census.

MENTAL HEALTH INDICATORS

Nevada's Mental Health Stakeholder Outcome Domains:

Symptom Reduction

Improved Functioning

Skilled Coping

Personhood

Consumer Involvement in Treatment Plan

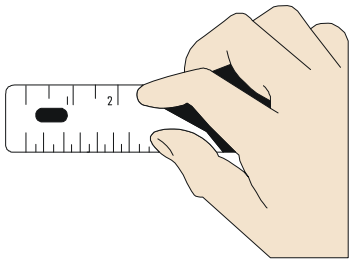
Community Integration

Social Functioning

Safety

Quality of Life

MENTAL HEALTH ACCOMPLISHMENTS



Performance indicators are instrumental in planning future services by helping predict program service demand

FISCAL YEAR 01-02 ACCOMPLISHMENTS

MENTAL HEALTH PROGRAMS—STATEWIDE PROJECTS

- Statewide Accreditation of all agencies: MHDS central office has begun efforts to coordinate and centralize all agency accreditation efforts to result in national accreditation for all MHDS agencies. Staff will facilitate and maintain these accreditation activities.
- The Division updated Nevada's comprehensive statewide disaster response plan, and has begun to focus on bioterrorism preparedness. Since the plan was completed in June 2000, it has been utilized on at least six separate occasions. For example, the use of this plan has resulted in immediate and effective mental health services to Nevadans in emergencies in Dayton, Reno and an Alaska Airlines air disaster.
- Third annual statewide training conference on Service Coordination: Because Service Coordination is a critical part of delivering community-based services, MHDS has begun to provide an annual statewide training conference. This training is designed to increase the skills of Nevada Service Coordinators in providing services to adults with SMI and people with developmental disabilities. Nevada's annual training conferences are now scheduled each August. Each annual conference has provided training to over 225 MHDS Service Coordinators.
- MHDS began the new Consumer Assistant Program in collaboration with Nevada State Personnel. These new positions are staffed by former mental health program consumers who will assist other consumers, infuse consumer perspectives in performance improvement and other activities designed to increase the user-friendliness of MHDS programs.
- MHDS began an interactive website, which was designed by MHDS clients and staff, and includes the ability to make electronic applications for services, as well as access publications, agency information and links with other state and national services and referral sources.
- Completed a pharmacy policy and procedure review that addressed security, accountability, storage and dispensing, which ensures uniform medication management in all agencies.
- MHDS is a member of the Caseload Evaluation Organization (CLEO). The purpose of the organization is to have each organization in the Department provide a statistical process for the projection of caseload growth by program. This information is used by management to develop precise budgets, staffing and evaluate program needs.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)

- SNAMHS increased the capacity of the Psychiatric Observation Unit from 10 patients to 20 with out additional staff or resources.
- SNAMHS increased inpatient capacity from 60 beds to 68.

MENTAL HEALTH ACCOMPLISHMENTS

- SNAMHS more than doubled the psychiatrist staff from 8 to 17, leaving only one vacancy that will be filled before the end of 2002.
- SNAMHS has re-opened 2 pharmacies at the Henderson and North Las Vegas site offices.
- Despite budgetary restraints and cuts SNAMHS has managed to continue to provide a full array of services at all sites.
- SNAMHS has improved staff training compliance from 25% to 80%.
- Implemented the innovative, community based, Intensive Supported Living Arrangement program to serve 8 chronically mentally ill who would otherwise remain hospitalized.
- SNAMHS hired long-time DHR employees into key positions including the Agency Director, Director of Nursing, and Medical Director, lending stability to these crucial positions.
- Local Area Network (LAN) installed at SNAMHS.
- SNAMHS has significantly reduced overtime expenditures in all categories.
- SNAMHS has improved standards of care, in line with JCAHO accreditation standards, and will apply for accreditation in December 2002.
- SNAMHS hired a new director of Health Information Services who is charged with bringing the agency into compliance with HIPAA regulations.

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)

- NNAMHS opened the Dini-Townsend Hospital on September 12, 2001. This state-of-the-art psychiatric hospital provides Northern Nevada with an inpatient hospital unequaled in the State in its ability to provide contemporary, high quality treatment in a clean, open and therapeutic environment
- Initiated in July 2002 an Intensive Supported Living Arrangement program to provide community based living options for individuals with high care needs and histories of extensive hospital use. This program has provided an opportunity to discharge patients who have resided in the hospital for months or even years.
- On November 12, 2002 NNAMHS opened the consumer run canteen. This canteen will serve consumers and staff by serving a variety of snacks, light meals and soft drinks. The canteen will also serve as a vocational training program for consumers. The canteen will be self supporting, requiring no state funding.
- In January 2002 NNAMHS passed a three year accreditation survey by the Joint Commission On Accreditation of Health Care Organizations with high marks and very few and insignificant Type I recommendations..
- Initiated a Family Psycho education Program. This evidence based program is designed to assist families of patients with schizophrenia to deal effectively with the symptoms manifested by their family member. NNAMHS staff received training in January, 2002 and currently have three "groups" in progress. The expected outcome for this program is a reduction in hospitalization for patients; an increase in family participation in treatment and greater support for individuals with schizophrenia to live in their own communities

Highlight:

The opening in September of a new, state of the art, 60 bed Dini-Townsend Psychiatric Hospital in Sparks, NV, allows for treatment in a clean modern setting.

MENTAL HEALTH ACCOMPLISHMENTS

RURAL CLINICS (RC)

- 6.5 new positions were funded for caseload growth plus 5.02 positions were funded to meet the existing backlog.
- The agency was budgeted to collect 1.2 million in TANF funding over the biennium, which provided a general fund savings of 1.2 million.
- Continued participation in the leukemia cluster emergency in Fallon, Nevada, including involvement in the two day workshop in July, facilitating the establishment of the Community Unity Response Team (CURT), and hiring and supervising a Service Coordinator for the affected families.
- Implementation of the Agency Suicide Intervention/Prevention Clinical Training Program.
- Utilization of videoconferencing for agency and cross agency meetings, resulting in significant cost savings in travel budget and labor.
- Successful budget presentations resulting in improving infrastructure in nursing service coordination and counseling programs. E.g., increased services to South Lake Tahoe.
- Personnel Analyst initiated collaborative effort with other agencies in rural Nevada to provide/make available mandatory training in rural Nevada, thus improving training opportunities while reducing costs.
- The Rural Nevada Continuum of Care (RNCoC)) is developing with the support of Rural Clinics stakeholders groups. Documentation of a strong well-developed rural continuum is essential if the continuum is to be successful in applying for up to $300,000 in HUD funds in May 2002.
- In December of 2001, Rural Clinics received a grant for $202,100 in BADA funds for the period January 2002 through June 2003 to develop programs in Ely, Tonopah, Hawthorne, Pahrump, Mesquite, Overton and Caliente.

LAKE'S CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER (LCC)

- The Sanity Commission process was eliminated in NRS 178 and language was changed to allow LCC staff to conduct sanity evaluations.

GOALS FROM THE MHDS STRATEGIC PLAN

- Provide and promote high quality and cost effective services in a safe environment
- Promote and support the least restrictive services possible in people's own communities while reducing reliance on institutional placement (strengthen community-based service to support people with multiple and complex needs).
- Ensure that services address the interests, rights and needs of each individual consumer serviced
- Utilize technology to improve accessibility to and availability of services and the efficient use of resources
- Update and maintain a plan to respond to emergencies and disasters in Nevada in a timely and effective manner.

SIGNIFICANT LEGISLATION AND OTHER ACTIONS

- NRS 433A.370, 433A.380 and 433A.390 were amended to allow for persons who have been involuntary committed to a mental health facility to be placed on convalescent or conditional leave for a period not to exceed 6 months. This change in the law is designed to allow for a consumer to be evaluated by staff and be re-hospitalized if necessary.
- State legislation passed by the 1999 State Legislature, authorizes judges to consider past mentally ill behavior when determining if an individual should be involuntary committed.
- State legislation, passed by the 1999 State Legislature, allows the Division to serve not only persons with mental retardation, but also persons with conditions related to mental retardation.
- Assembly bill 346 allowed for funding of a pilot project in Las Vegas for the provision of a program of intensive and integrated community services to adults who are seriously mentally ill and homeless.
- BDR for a State of Nevada committee on homeless which came about as a result of the "Nevada Policy Academy Team of Homeless Families with Children."
- BBC Research and Consulting, contracted by the State of Nevada Dept. of Business and Industry, Housing Division, conducted a housing needs assessment of special needs population in the greater Las Vegas and greater Reno/ Sparks area. See website at: http://nvhousing.state.nv.us.

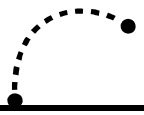
MENTAL HEALTH HIGHLIGHTS

The Division of MHDS strategic planning process began in 1995. The plan was again updated in 1997 and again in 2000. The 2000 Strategic Plan addressed national standards, service gaps, budget and program planning. Additionally, the division developed a legislative planning process to reflect a timeframe in which an MHDS Needs Assessment occurs every even-numbered year, with strategic planning reports made in alternating (odd) years. Therefore legislative planning could be linked with specific FY04/05 budget efforts to findings reported in the Needs Assessment and Strategic Planning. This 2003 Strategic Plan and the upcoming 2004 Needs Assessment are being developed to assist MHDS through the FY06/07 biennium.

MH Challenge 2003-2005	*Plans for meeting the challenge*
☑ Maintain /expand funding support during state general fund budget reductions	• Reinstatement of FY03 budget reductions first priority, then budget for additional staff and resources to meet demands for programs showing the greatest need. • Apply for additional federal funding to support the expansion of Nevada's data infrastructure and programs.
☑ Involve consumers and other stakeholders in the planning and quality assurance process.	• Fully operate new Consumer Assistance Program (CAP). • Refine collection/reporting of consumer perceptions and satisfaction.
☑ Inpatient demand beyond staffing capacities	• Put into operation, increased bed capacity in Southern Nevada. • Expand PES in Southern Nevada. • Address emergency room crisis in southern Nevada hospitals.
☑ National accreditation of all MHDS agencies	• Obtain adequate staff infrastructure to under take accreditation. Train all levels of staff in planning and development to meet external standards. • Expand quality assurance program and continue to monitor program's consumer oriented outcome measures.
☑ Technology	• Replace obsolete MIS system in all MHDS agencies. • Internet connectivity for all clinical and fiscal all staff. • MHDS Website updates and improvements • Telemedicine.
☑ Maintain adequate funds for use of new generation antipsychotic medications	• Invest in newer, state of the art medications that provide consumers relief from mental health symptoms and reduce the demand for hospitalization.
☑ Improved mental health services to correction consumers	• Expand mental health courts • Assist NV correctional system in reorganization.
☑ Disaster Response Bioterrorism Preparedness	• Develop adequate infrastructure and staff development to provide crisis counseling, critical incident debriefing, and related activities. • Develop interstate linkages.
☑ Improved services to homeless mentally ill consumers	• Augment federal and state funds to provide continuity of care from a level of homelessness to a level of self sufficiency based upon the individual needs of each person.

DEVELOPMENTAL SERVICES

Establish
partnerships
among stakeholders
as to the direction of
public mental health and
developmental services in the state.



Developmental Disabilities Stakeholder Values

Choices:
People choose personal goals and services. Choices include, but are not limited to, where to live and work and how to use free time.

People are Included in the Community:
People live and participate in the community interacting with other members and fulfilling different social roles.

Relationships:
People have friends and relationships and remain connected to their natural support network.

Rights:
People exercise their full rights as citizens and if their rights are limited they are afforded due process.

DEVELOPMENTAL SERVICES:
Involving Stakeholders

MISSION

It is the mission of each Regional Center to provide residential and community-based services for people in Nevada with developmental disabilities and related conditions. Agencies provide person-centered planning so that people can make choices about their lives, live in the least restrictive manner possible and live productively as part of the community.

PERSON DIRECTED SYSTEM

The regional centers work in partnership with people who have developmental disabilities and their families to ensure they can select and direct meaningful services applicable to their principle goals, needs, and desires. Services are designed to maximize each person's independence, capabilities and satisfaction through a process referred to as person-directed planning.

Existing and available resources throughout the community are mobilized to ensure that support services are based on the value that all people with disabilities can and should decide for themselves what happens in their lives. The principles necessary to accomplish this begin with the person's desired future and focus on the person's abilities and capabilities.

DS is pursuing a Vision for the Year 2002

Background:

During 2002 the Division participated with a variety of interested groups, consumers and persons to update and broaden service vision and goals. DS was also involved in the State Strategic Planning effort (AB513).

Process of Including Stakeholders:

People served, families, boards, advisory groups, and service providers participated in regional meetings.

Our long range service vision continues to emphasize community based services.

SERVICE VISION 2002

The Service Vision includes six areas of service and defines specific goals for each area. They are:

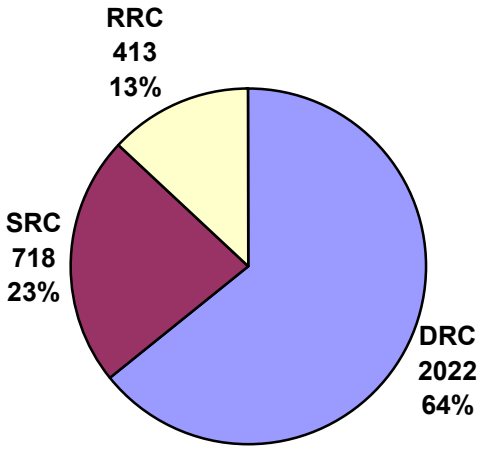
Service Accessibility

- Services will be available to 100% of eligible persons who request it. Nevada's growth continues to create a greater service need.

Service Coordination

- Provide service coordination to help all participants obtain individually chosen goals.

Fig. 24 NUMBER AND PERCENT OF PEOPLE SERVED BY REGION FY2002



Regional Centers

DRC - Desert Regional Center
SRC - Sierra Regional Center
RRC - Rural Regional Center

PERSONS

Developmental Services Stakeholder Values

Dignity and Respect:
People are respected, have privacy, personal possessions, and choice about the sharing of personal information.

Health:
People have health care services adequate to achieve the best possible health.

Safety and Security:
People are safe, free from abuse and have economic security in their life.

Satisfaction:
People are satisfied with the services and assistance they receive in pursuing their goals.

DS GOALS

Service Accessibility

Service Coordination

Family Support

Jobs and Day Training

Residential Supports

Service Quality

Personal goals require defining the future and identifying and coordinating services that can be effective and efficient for goal attainment. Part of Service Coordination is to assure and enhance each individual's rights; including facilitating self-advocacy, providing personal advocacy, and supporting legal services for all persons based on individual need.

Family Support

- *Family support services will be provided on an ongoing basis to 100% of the families in need and based on individual needs.*
- *All residential care provided to children will be in community based settings. Nevada will develop in-state services for children.*

For normal development, children need to live in a family setting, not in an institution. Achievement will require a broader array of supports for families in their own community.

Jobs and Day Training

- *Of adults receiving day services, 100% will have a choice to work or train in an integrated setting in the community.*

The development of community-based job and day training supports is critical for increased work options, productivity, and community integration.

Residential Supports

- *Of people receiving residential supports, 100% will be living in chosen living arrangements to include their own home or six bed or smaller community settings. No more than 5% will be in State ICF/MR based settings.*
- *Supported living arrangements (SLA's) will be available to 75% of adults receiving residential assistance through Division funds.*

These goals will mean greater individualized service choices. Achievement will require continued dispersal of large facilities and the creation of more supported living arrangements.

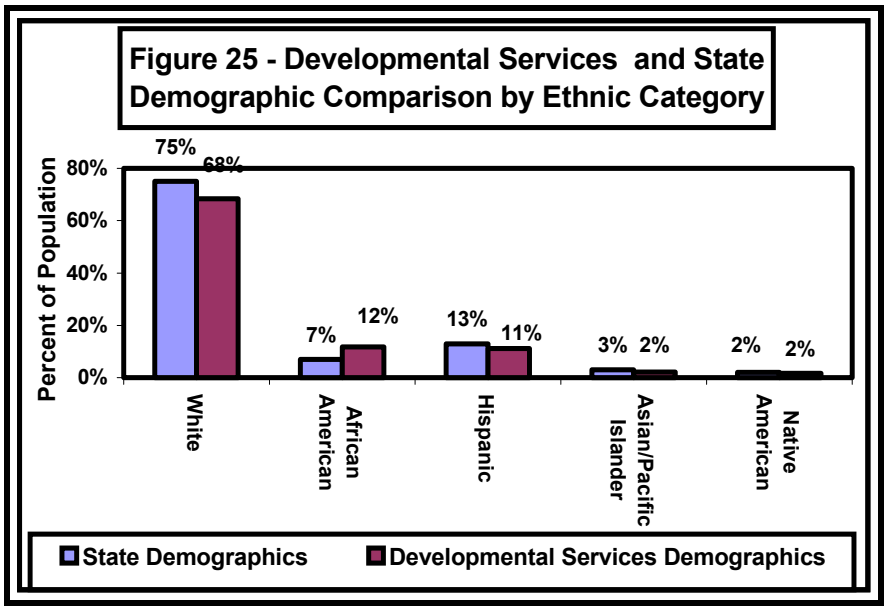
Service Quality

- *Services will achieve and maintain standards of The Council on Quality and Leadership in Supports for People with Disabilities (The Council – formerly the Accreditation Council).*

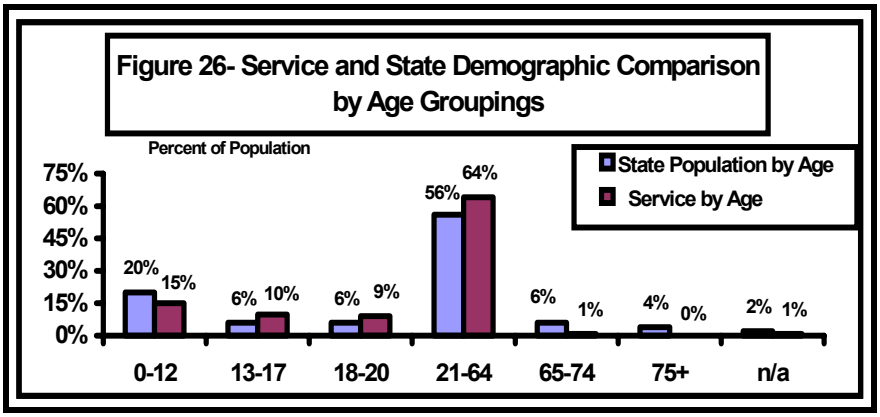
To assure high quality, services must meet independent, nationally recognized, standards of care.

Who are the Recipients of Developmental Services

Fifty seven percent (57%) of the recipients of Developmental Services are male and 43% female. The ethnic composition is 68% White, 12% Black, 11% Hispanic, 2% American Indian and 2% Asian/Pacific Islander. Nevada's ethnic population characteristics are compared to DS's persons served in **Figure 25.**



People receiving services consist of 25% children (aged 0-17) and 75% adults (aged 18+). Persons served are more likely to be in the age group from 21 to 34 years old (36%). The elderly comprise 3% of the service population (55+). The State of Nevada general population is contrasted with the developmental service population in **Figure 26.**



Nevada's Demographics are Reflected in Persons Served

DS Mandate for Services

Nevada Legislative Intent

To charge the Division with recognizing its duty to act in the best interest of its clients by placing them in the least restrictive environment (NRS 433.003.2)

Federal Legislative Intent

"…to assure that individuals with developmental disabilities and their families have access to culturally competent services, supports, and other assistance and opportunities that promote independence productivity, and integration and inclusion into the community."

(The Developmental Disabilities Assistance and Bill of Rights Act Amendments of 2000)

DEVELOPMENTAL SERVICES' PROGRAMS

SERVICE COORDINATION

All people who are eligible for services from a regional center are assigned a service coordinator (case manager). Service coordinators assist people in obtaining needed benefits and assessments. Through person-directed planning, the service coordinator works directly with the person (and others), helping the customer articulate his or her needs for the future. The service coordinator helps the person learn about and choose from available service providers and supports. Jointly, the customer and service coordinator develop service plans that focus on achieving consumer determined outcomes.

Service coordinators visit with the individuals at least quarterly to assess the efficacy of the plan and whether services are being provided as intended. Progress toward personal goals is assessed on an on-going basis. Plans may be updated and changed as the consumer's goals and needs for support change. At least annually, the service coordinator assesses the satisfaction of the consumer with the supports and services being received.

Service coordinators have a very important relationship with the consumer they work for. They are responsible for overseeing the quality of services and for making sure that the consumer plan of care and treatment is implemented and changed as needed. People are encouraged to choose their own service coordinator.

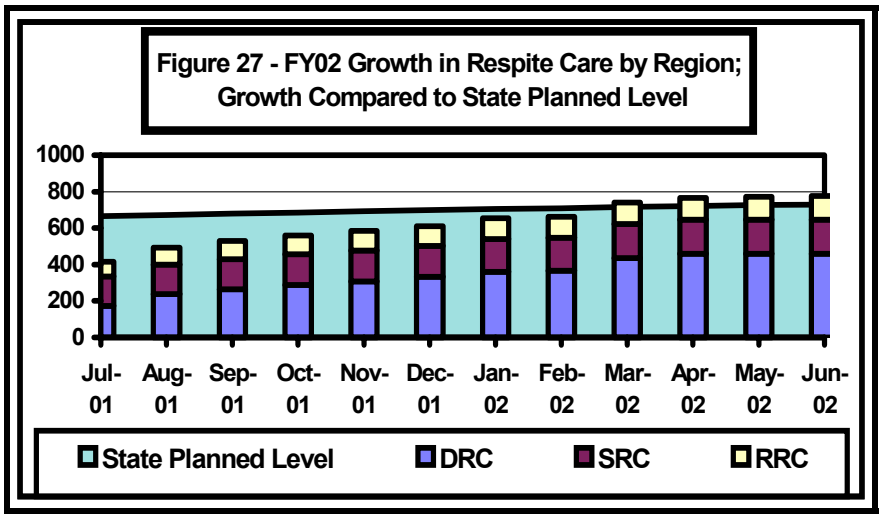
FAMILY SUPPORT SERVICES

The Family Support Program was developed to assist families of individuals with developmental disabilities and related conditions to care for their relatives in their family home. All individuals who are eligible for services through Desert Regional, Sierra Regional, and Rural Regional Centers are eligible to apply for Family Support Services. The goal of the Family Support Program is to prevent costly out-of-home placement by assisting the family in caring for their relatives. Any charges for services are determined by using a sliding fee scale. Most consumers who are eligible for Medicaid pay no fees for services.

The Family Support Program provides the following services to consumers and their families:

1. Respite
2. Purchase of Service Supplements
3. Clinical Assessments
4. In-Home Training Services
5. Counseling
6. Family Preservation Programs

Respite provides temporary care in or out of the family home. Respite gives families a break from the day-to-day responsibilities of caring for their loved ones. Families receive respite vouchers to use at certified or licensed respite providers, in rural Nevada, or other providers of their choice. The amount of the voucher is based on the family's request, its financial co-pay (if any), and the available funding in the regional office. Families choose their respite providers and select the days and times when they want to use their vouchers. The respite provider charges the family any co-pay (if one is due) and then bills the remaining cost to the regional center after providing the respite services. Families may use their yearly allotments all at once for a vacation or in small monthly increments. The choice is up to the family. **Figure 27** shows growth in this program exceeding planned levels in Fiscal Year 2002.



Purchase of Service Supplements (POS) are provided to families to assist them with the excess costs of services for their relatives. All alternative funding sources and existing resources must be used by the family before the POS is issued to them. Families who request a POS must meet financial guidelines to receive vouchers from the DS agency. The POS is available to eligible families one time per year, for a maximum purchase of $300. The family can use the voucher with any vendor or provider that accepts it. The service/goods are provided to the family and the State Agency is billed for the service. Examples of items that can be purchased with the voucher include such things as:

- Medical/dental services not covered by insurance
- Special diets, clothing, special equipment
- Car seats, beds, special furnishings
- Recreation, leisure needs, respite
- Food, rent, utilities

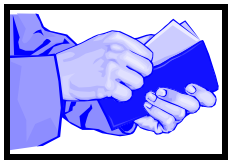
Studies have consistently shown higher quality of life in community settings.

Family Support Programs assist families of individuals with developmental disabilities to care for their family member at home

DEVELOPMENTAL SERVICES & PROGRAMS

Clinical Assessments help an agency team develop training programs with the individual

Family Preservation provides monthly cash assistance to low-income families caring for relatives with severe or profound develop-mental disabilities



Clinical Assessments are available for consumers who are in need of assessments or evaluations by a social worker, psychologist, or nurse. The assessments provide information that can be used to assist the individual's treatment planning team to develop training programs, and help the person gain services, obtain a job, move to a community residential program, etc. A sliding fee scale is used to determine if the individual is responsible for any costs. Medicaid and private insurance companies will be billed for the covered individuals who use the service. Families who are uninsured or who are unable to pay for the services will not be required to do so when funding is available through the DS agency.

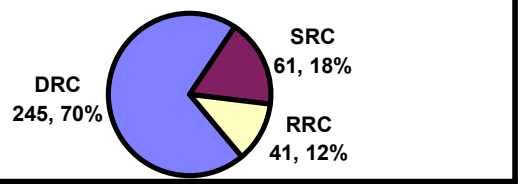
In-Home Training is available to consumers and their families who request assistance in their home with teaching skills that can help the family to cope better with their relative's special needs. The in-home trainer can work with individuals and their families in such areas as personal care, meal preparation, safety and leisure skills, transportation, behavior management, etc. The family identifies the training needs with assistance from the service coordinator. Training can be provided on a short or long term basis depending on the person's needs and the availability of funding in the DS agency.

Counseling is available to individuals and their family members to provide support and guidance in problem solving. Many different areas of need can be addressed with counseling services including; personal independence, self-esteem, community participation, social-sexual issues, work issues, etc. The individual and/or the family can choose the counselor and most services can be billed to Medicaid or private insurance. A co-pay may be charged if the person is able to contribute to the cost.

The Family Preservation Programs provides cash assistance to low-income families caring for their relatives with severe or profound developmental disabilities in the family home. The financial assistance can be used for a variety of needed services (supplies, equipment, transportation, general income supplement). The monthly allotment may vary from family to family and is determined by using a sliding fee scale and the available funding in the state budget. **Figure 28** shows program agency caseload percentages for this program.

Any individual or their family member who wants to apply for Family Support Programs should contact their service coordinator (case manager) for more information or local DS agency to open a case for services.

Figure 28 - FY02 Family Preservation Program: Average Caseload by Region



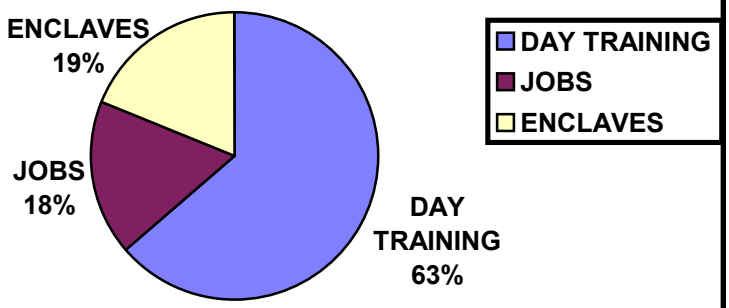
JOB AND DAY TRAINING PROGRAMS

All adults who are eligible for services from Desert Regional Center, Sierra Regional Center, or Rural Regional Center are eligible for Jobs and Day Training Services. These services vary in the type and intensity of supports to allow individuals vocational choices. Supports range from pre-vocational and vocational training in supervised, structure settings, to enclaves (supervised work groups in community job setting), to supported employment, including activities needed to sustain paid competitive employment or follow-along services. Regional Centers contract with private, nonprofit organizations that operate Community Training Centers and other qualified providers that offer training choices to consumers based on their interests and skill levels.

Job Services are available to consumers who need assistance to secure and maintain jobs in the community. Regional Centers contract with various private agencies as well as work cooperatively with the Bureau of Vocational Rehabilitation to provide work skill assessments, job development, job training, and follow along services through job coaching.

Community Based Work Groups (ENCLAVES) provide individual's vocational opportunities in the community and the opportunity to acquire the necessary skills that will assist them in sustaining employment in the community. It enhances their understanding of the community in which they live and the opportunities that are available to them. It also allows individuals to work outside of the facility-based environment (workshop) without being required to meet the industrial standards of the job. Individuals with the supervision of a staff member are placed at a job site in the community. The staff member is present to offer support and help should it be needed. Most enclaves are part time. Currently, statewide enclaves are performing work at many local businesses; (food services, manufacturing, building and grounds, service industries and janitorial services).

Fig. 29
EMPLOYMENT SETTINGS FY02



Job and Day Training Programs

Work is not only an important contribution to one's self esteem, but also links one to society

Residential Programs provide alternatives to more expensive and restrictive institutional settings.

Choosing where, how, and with whom to live reflects one's personal power

Day Training Services are available through Community Training Centers (CTCs) and other qualified providers. Day training is designed to provide vocational experiences for people who need more intensive personal or behavioral supports or to assist individuals to learn skills necessary for success in a job.

Figure 29 (previous page**)** shows employment settings for the three programs.

RESIDENTIAL SUPPORTS

Residential Supports are available to people who require assistance. All individuals who have open cases with Desert Regional Center, Sierra Regional Center, or Rural Regional Center may request residential supports. This program is designed with a goal of allowing people to live in a home of their choice as self-sufficiently as possible. Most people prefer their own home rather than institutional care. These are important alternatives to restrictive and costly institutional settings.

Residential services are funded by using the individual's own resources (Social Security benefits, job income, etc.) and supplementing these as needed with state and federal funds. The Nevada Medicaid Program funds the costs of many support services if the individual is eligible. The State also provides funds to assist the person with expenses of living in the community.

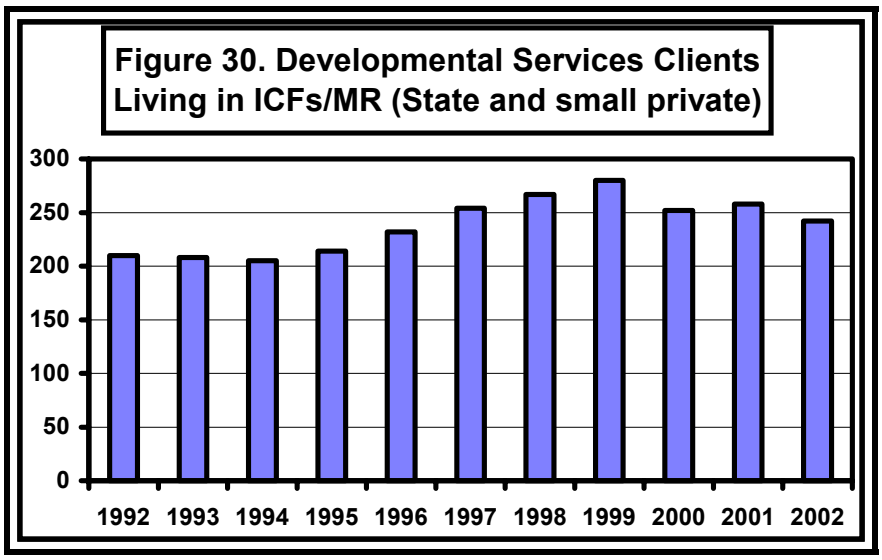
The following residential options are available:

1. Intermediate Care Facilities for people with mental retardation and related conditions. (ICFs/MR)
    a. State ICFs/MR
    b. Small Private ICFs/MR
2. Intensive Supported Living Arrangements
3. Supported Living Arrangements
4. Private Group Homes
5. Developmental Homes

State ICFs/MR provide twenty-four hour supervision and training to individuals who require intensive support, medical care, treatment, and training. Located at Desert Regional Center or Sierra Regional Center, these campus-based homes are licensed to provide services to approximately 136 people. The homes house from four to twelve people. Each facility is staffed by state employees on a 24-hour basis and must follow strict Federal and State guidelines. The programs are funded by Nevada Medicaid, and offer specialized services. This setting is also the most restrictive. **Figure 30** (next page) shows the number of people per year in all the programs.

Small Private ICFs/MR provide residential services in small community residences for up to six people. The individuals who require this level of care need intense treatment and training but live in community neighborhood houses with 24-hour awake supervision and support. The services are provided by private organizations (or the state) and are funded by the Medicaid Program. The same Federal

and State guidelines guide larger ICFs/MR homes. The services provided in an ICF/MR Small are considered less restrictive than the ICF/MR services provided in large State run facilities because they are located in community neighborhoods.



Intensive Supported Living Arrangements (ISLAs) provide services in community residences for up to four individuals who live in their own homes. The services are provided by private organizations. These services were developed as an alternative to an ICF/MR so that individuals could live in the community while receiving intensive support and training. Individuals who choose ISLAs must be capable of contributing to the costs of their services, and may have intense medical or behavioral training/treatment needs. Twenty four hour supervision is provided .

Supported Living Arrangements (SLAs) are individualized living supports that supplement individuals' resources in their own homes. Assistance is designed to help persons achieve and maintain maximum independence in the community. Supports are contracted with private providers. Support staff visit the individual on an individualized schedule that depends on a person's needs and preferences. The services are paid for by the individual and may be subsidized by the State Agency and/or Nevada Medicaid. This is the most self-determined level of support for individuals and considered the least restrictive support option for adults. Because of this, SLAs are a preferred program (See **Figures 31 and 32** next page).

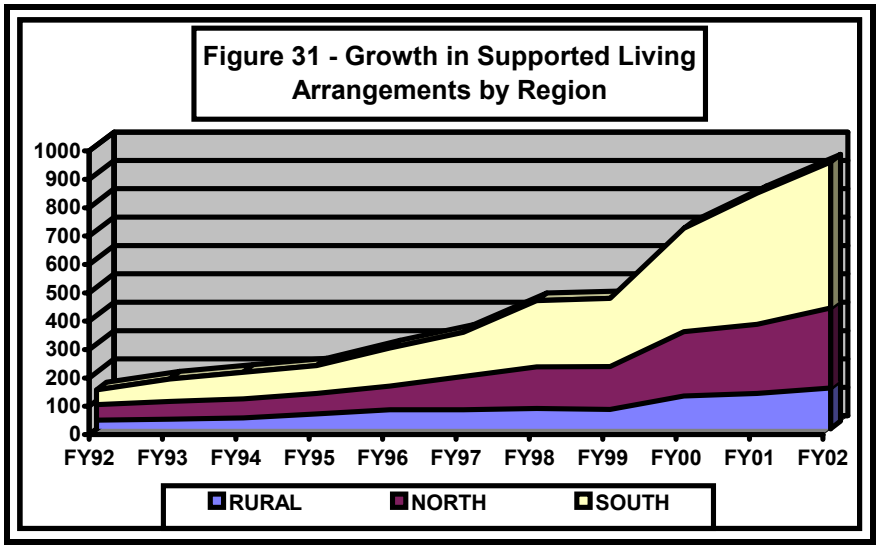
Private Group Homes are located in community neighborhoods and serve up to six individuals. The services are provided by private organizations. The homes are certified by the DS agency. They are able to serve individuals who are age 18 years or older and need some support and training. There is no awake staff at night and individuals may have intermittent periods unsupervised if their treatment team approves it.

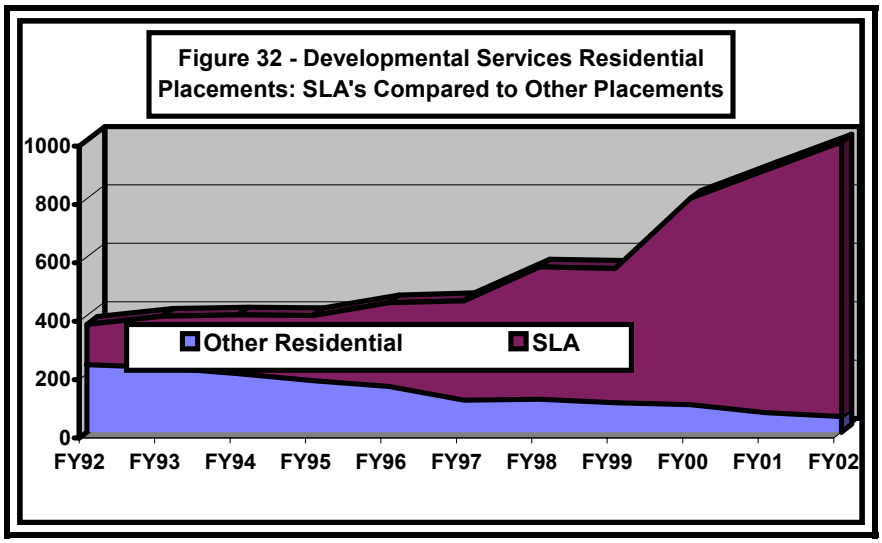
Supported Living Arrangements

Individualized living supports that supplement individuals' resources in their own homes. Helping persons achieve independence in the community.

DEVELOPMENTAL SERVICES & PROGRAMS

Growth in the SLA program reflects DS's goal of placing individuals in the least restrictive environment possible





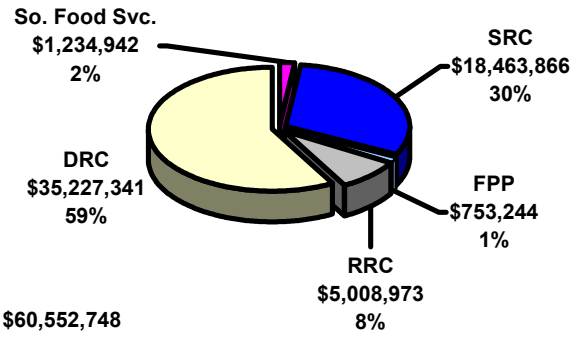
Host Homes are private homes in the community that typically serve up to four individuals who are usually younger or more dependent individuals who desire or need a more "family" type of living situation. The providers are private people who choose to have their homes licensed and/or certified to care for individuals with a developmental disability. The people who live in these homes are included in all the provider family's life and activities.

DEVELOPMENTAL SERVICES FUNDING SOURCES AND EXPENDITURES

Funding for Developmental Services agencies for fiscal year 2002 was $60,552,748. The allocation of funding by the DS agency is presented in **Figure 33**. This includes the allocation for the Family Preservation Program (FPP).

Revenue sources for Developmental Services are comprised of three main sources: State General Fund (54%), Federal (43%) and fee, charges and other sources (3%). Most of the federal funds represent the federal share of Medicaid (50% State share, 50% Federal share). Eligible Medicaid services are ICF/MR and community services through the Medicaid Home and Community-Based (HCBS) Waiver.

Figure 33 - DS Agencies Fiscal Year 2002



STAFFING TO MEET SERVICE DEMANDS

Background

During the 1999 session the legislature approved the administration plan to address current and projected waiting lists. The plan funded service growth evenly over the course of the biennium. The plan is intended to fund anticipated family and community based services such as family support, respite, service coordination, and jobs and day training such as provided through the Community Training Centers (CTCs). The plan also converted some ICF/MR placements to community living. The Medicaid Home and Community Based Services Waiver (HCBS) provides federal match for most of the services.

Service Levels are planned in order to respond to current and projected waiting lists

DEVELOPMENTAL SERVICES WAITING LISTS

Waiting Lists are a key indicator of ability to meet public need for services.

Waiting Lists FY 2002:

Waiting lists decreased by the end of FY02, along with large increases in new cases.

Total Persons Served - Statewide, applicants pending decreased from 151 in June FY00 to 88 in June FY02. This represents a reduction of 72% in the waiting list. During the same time the total statewide caseload grew from 2637 cases in July FY00 to 3153 cases in June of FY02. This was an increase of 516 new cases or an increase of 20%.

Jobs and Day Training - The waiting list decreased from 103 in July FY00 to 74 in July FY02. This is a 39% decrease.

Residential Waiting Lists - Residential waiting lists slightly decreased from 189 in July FY00 to 187 in June FY02. This does not reflect the planned and funded growth the Division is phasing in services and will fund 89 more support placements by the end of FY03. Waiting lists for community residential supports have decreased despite the huge growth in new placements. The number of Supported Living Arrangements grew from 707 in June FY00 to 941 in June of FY02. This is an increase of 234 new placements or a growth of 33%.

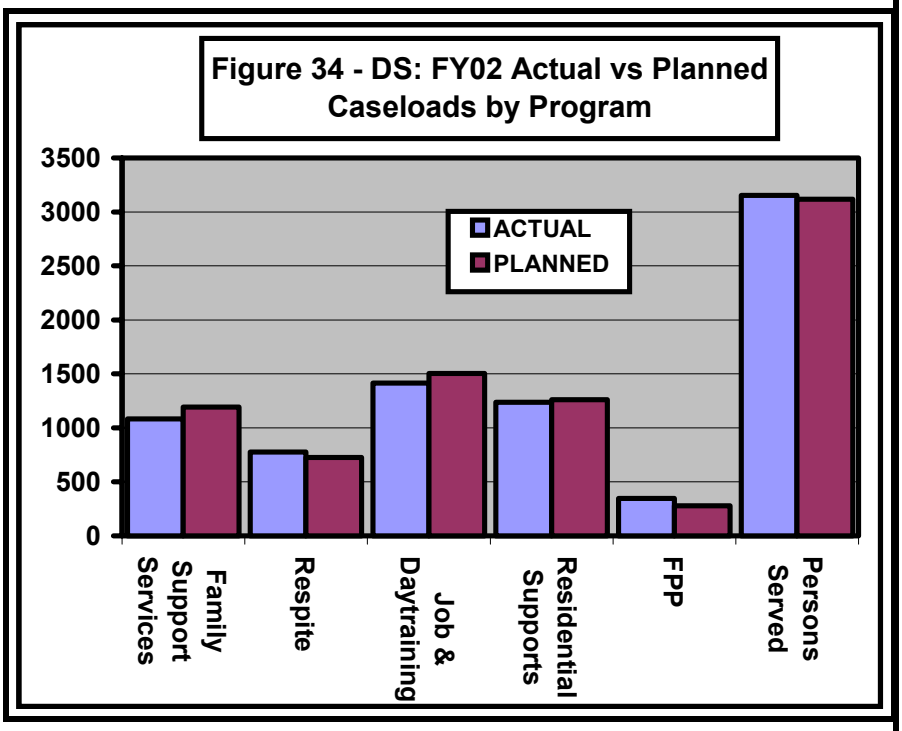
Respite - The respite program has not had a waiting list in the past, since all persons are enrolled and the available resources are spread amongst them. Families enrolled in the respite program have increased from 666 in June FY00 to 776 in June of FY02. This growth of 110 families represents a 17% increase. This exceeds the funded level of 726 families and has resulted in the beginning of a waiting list for new recipients in the Northern Nevada area to avoid excess reduction of services to current cases. As the number of families increase, family respite allotments may be reduced.

Family Preservation Program (FPP) - The Family Preservation Program, now covers persons with severe as well as profound developmental disabilities, increased from 276 recipients in July of FY02 to 347 in July of FY02. This was an increase of 91 families served or 49%.

Residential Outcomes - Agencies continue to progress at converting to community and individualized services. In June of FY02, 89% of all people receiving residential support lived in community settings of 6 or fewer individuals. This is a 3% increase from 86% average in June of FY 00. In addition, 95% of persons in community living [Category 11] are receiving individualized service plans as driven by a Supported Living Arrangement contract. This is an increase of 7% from the 88% average in FY 00.

Summary

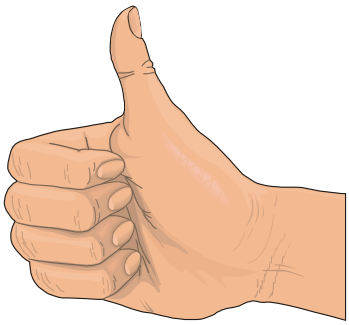
Developmental Services has grown considerably over the last eight years. The last two years are no exception. Overall, Developmental Services reduced the total caseload waiting list by 42% while the caseload grew by 516 new cases or 20%. As of June FY02, the applicants pending represents less than 3% of the total persons served of 3153. High demand exists for service coordination, family supports, and residential supports. The requirement to serve persons with related conditions has added over 347 new cases to the service delivery system. Service targets continue to be met while waiting lists have been significantly reduced. **Figure 34** shows attainment of planned levels in Fiscal Year 2002. **Figure 35** displays the growth in caseload and remaining waiting list over the last nine years. DS continues to phase in newly funded services. This will continue through FY03.



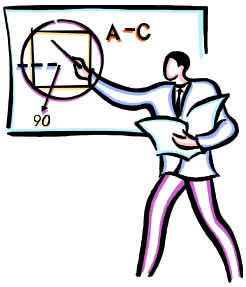
MEASURING EFFECTIVENESS AND CONSUMER OUTCOMES IN DEVELOPMENTAL SERVICES PROGRAMS

Developmental Services within the Division of Mental Health and Developmental Services collects outcome information on a monthly basis. A variety of measures are collected that are applicable at individual, program, regional, and statewide levels. This information is used to track progress and identify areas for improvement.

OTHER OUTCOMES



High demand exists for service coordination, family respite, and residential support services.



PERSONAL OUTCOME MEASURES

AUTONOMY

People choose their daily routine.

People have time, space, and opportunity for privacy.

People decide to share personal information

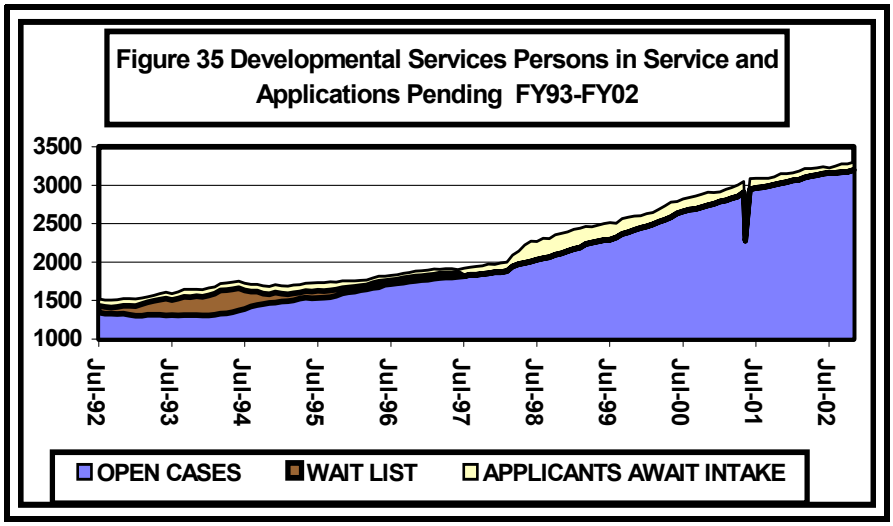
People use their environments.

HEALTH AND WELLNESS

People have the best possible health.

People are free from abuse and neglect.

People experience continuity and security.



Customer Based Outcomes and Satisfaction

In order to continually assess services, personal outcomes for persons served are captured through extended individual interviews with the person and people who know them best. Interviews are based on national accreditation standards and measure service values such as dignity, choice, relationships, health, rights, satisfaction and community inclusion. These are the same values as defined in State, Federal Legislation and in Position Papers of the National Association of Retarded Citizens.

Interviews are conducted using interviewers who are trained by The Council on Quality and Leadership in Supports for People with Disabilities (The Council). Interviewers use *The Council's Personal Outcome Measures*, a process that is used by The Council nationwide to determine accreditation for agencies providing services to people with disabilities. The 25 Personal Outcome Measures provide the means to determine if agencies are providing the supports and services that people receiving services expect and are effectively in helping them reach their desired life outcomes. The Division contracts with the University of Nevada, Center for Excellence in Developmental Disabilities (Department of Education, UNR) to provide independent interviews throughout the state. The University of Nevada, Las Vegas faculty and students participate in Clark County, while the University of Nevada, Reno faculty and students conduct the interviews in Washoe County and outlying rural areas. On-going findings provide feedback to each individual's planning team and support staff, as well as to programs, regional agencies, and statewide levels. Because the focus of services is on supporting people to achieve their individually-defined personal outcomes, information provided by this project is invaluable in the development of each

agency's internal goals and objectives and for strategic planning. A Biennial Legislative Report is also provided.

Community Inclusion as a performance indicator

Developmental Services tracks a number of indicators that express the speed of access to services and the level of community inclusion for persons served. Access is tracked by measuring the median number of days it takes for a person to have eligibility determined. This includes the application process and necessary background and assessments that must be accomplished. Community inclusion is also important for residential supports. It is monitored by knowing the number of people that are enrolled in the Medicaid Waiver. This Waiver provides for community based funding instead of institutional care. More generally, the percentage of community residential supports versus the percent of people in institutional care reflects an overall level of community inclusion.

To further understand the quality of community inclusion, the percentage of persons who have individualized supported living arrangements measures the degree to which people live in their own homes and have individualized support plans. Community support waiting time measures the level of access to community residential supports.

By having a small number of children in institutions, we measure the ability of the system to keep children integrated, rather than institutionalized. By living in the community, children are exposed to the full range of experiences necessary for maximum development.

Maximum independence is an additional goal for persons with mental retardation and related conditions. While many people will not gain total independence, each person is supported to be as self sufficient as possible and to live as part of the community. The percentage of jobs and training integrated employment settings portrays this. Inclusion provides expanded opportunities to participated in the community.

These system level measures are reported as performance indicators during the budgeting and legislative process. Care has been taken to coordinate with national databases that can be used to benchmark Nevada with other states.

Other Outcomes

In addition to system outcomes described above, component programs such as service coordination (case management), family support, jobs and day training, and residential support have identified outcomes that track progress.

The outcome evaluation system in Developmental Services programs is designed to provide information that supports decision making at all levels, from policy to individual service decisions. The intent is to track information that reflects important service results for people served and provides a basis for decision-making that is in the best interest of stakeholders. In other words, the goal is to provide the best possible service to people with developmental disabilities and related conditions and the tax payers of Nevada.

DS PERFORMANCE INDICATORS

PERSONAL OUTCOME MEASURES

IDENTITY

People choose personal goals.

People choose where and with whom they live.

People choose where they work.

People have intimate relationships.

People are satisfied with services.

People are satisfied with their personal life situations.

RIGHTS

People exercise rights.

People are treated fairly.

DEVELOPMENTAL SERVICES ACCOMPLISHMENTS

Nevada continues to improve access to services and opportunities for community living.

Accomplishments in Developmental Services - FY 2002

New Service Population Expands: People with Related Conditions

Since June 1999, persons with related conditions has increased from 80 persons to 360 persons served (an increase of 350%). This service population currently represents **11%** of the total population. This was the result of the expansion of the criteria for eligibility for Developmental Services to include conditions related to mental retardation, such as autism, cerebral palsy, epilepsy, etc. This has allowed persons with these developmental disabilities and their families to receive assistance form MHDS who previously had no access to needed services. Some 25% of new cases opened in FY02 were persons with related conditions.

Accreditation Process: Regional Centers expand Accreditation.

Developmental Services continues to improve the quality of services. Sierra Regional Center was accredited by *The Council on Quality and Leadership in Supports for People with Disabilities* in 2002. With Desert Regional Center, currently accredited, 88% of the state service population is served by accredited regional centers. Rural Regional Center is preparing for accreditation in 2003.

The University Center for Excellence in Developmental Disabilities (University of Nevada) provides feedback on the quality of services by independently interviewing persons served in regional services. The focus is on improving the quality of supports related to personal outcomes of persons receiving services.

Converted ICF/MR State run Programs to Community Living Options.

Developmental Services continues to convert state run institutional beds to provide community-based intensive supports. Eighteen beds were converted during FY 02. This offers persons the option to live in the community and receive quality services. Persons living in state run ICF/MR programs represent less than 5% to the total persons served in Developmental Services. The majority of persons receiving residential supports live in small-sized community settings. As of 2001, Nevada has the 6th highest percentage (76.6%) in the nation for people living in community residential settings of 1-3 occupants, (U. of Minnesota, Research & Training Center on Community Living, 2002).

DEVELOPMENTAL SERVICES ACCOMPLISHMENTS

Supported Living Arrangements (SLAs) Continue to Grow.

The supported living arrangement program has grown over the past twelve years to provide personalized community living to 941 persons who would otherwise require more restrictive and costlier care. Expanded SLA supports allow people the choice to move from ICF/MR programs to their own homes in the community. Of the 941 SLA's in the community, over 300 provide 24 hour care. SLA's represent 95% of persons served in the community.

Improved Access to Developmental Services.

Expanded satellite offices were opened in Las Vegas and the rural region. They provide better access for intake and service coordination. Within all regions the application process has been improved with intake staff that assist new applicants. In FY 02, the median number of days to accept and assess persons was 46 days.

Family Supports Broadened to Help People Remain in Their Natural Homes.

Through family support programs some 1,768 persons can live and receive services in their own home. Developmental Services provides expanded family support services to over 1,000 families a month, This includes respite services as well as purchase of services, counseling, and screenings. In-home training and in-home supported living services divert people from waiting lists for out-of-home placement. Direct financial assistance (the Family Preservation Program) has been expanded to cover additional families who care for a family member at home. The expansion has been supported by the use of TANF funds.

Service Coordination Improved Accessibility.

Since FY 2000 Developmental Services total persons served has increased about 20 percent for a total of 3,153 persons served in June FY 2002. Projections indicate a total service population approaching 4,000 persons by the end of FY 05. During this high growth period, assessment times have been greatly reduced and the number of applicants pending service has also decreased.

Jobs in the Community Promote Productivity and Integration.

Developmental Services served over 1,400 persons in jobs and day training programs in FY 02. Some 516 persons were served through integrated employment programs. Of that total, 268 persons were working in enclaves (small work groups in community businesses). This employment option attracts people because of a higher average wage paid per hour than in non-private settings.

Greater availability of service through new eligibility Definition.

Improved Access to Services.

Improving quality of service through the Accreditation Process.

Broadening and Strengthening of Programs.

Service Coordination addressing waiting lists.

DS Challenge 2003-2005	*Plans for meeting the challenge*
INCREASED DEMAND FOR SERVICES	
Nevada's growth continues to be a challenge. Managing increased demand for services for people with Developmental Disabilities and Related Conditions will impact the service delivery system. Waiting lists for services are a reality throughout the state, especially for residential services. Payments and support for families are being reduced to accommodate increasing requests for family support services.	Budget for growth through analysis of service demands and needs assessment. Make more effective use of existing resources, reduce paperwork, and develop a more cost effective infrastructure to deliver and monitor services. Emphasize cost effective programs such as service coordination, family support, and community living. Maximize federal participation through the Medicaid HCBS Waiver and TANF funds to help defray service cost. Assist community provider efforts to obtain additional resources to maintain quality services. This includes fiscal intermediary services : Develop more efficient and responsive means for people to choose and select the kinds of services they need.
PROVIDE FOR MORE COMMUNITY LIVING ALTERNATIVES	
Persons who require intensive supports due to medical and/or behavioral needs continue to live in ICF/MR facilities, both in Nevada and out-of-state. All persons, regardless of their level of disability, should have the opportunity to be served either in their natural homes with sufficient assistance to the family, in therapeutic foster homes, or other community living arrangements.	Assess and evaluate the intensive needs of persons living in institutional settings, and develop strategies that offer persons the choice to live in integrated environments. Increase available resources for Family Support Services and Family Preservation payments to families to re-unify and maintain families with persons who have intensive support needs. Work with providers to assist service users to identify and access community resources.

CONTINUE TO FOCUS ON PERSON DRIVEN SERVICES, AND QUALITY IMPROVEMENT EFFORTS.

Focus efforts to discover, support and satisfy person-defined goals. Maintain on going quality improvement strategies for persons to attain personal outcomes with the best use of resources. Continue to plan and evaluate services based on feedback from service users.

Develop additional ways for persons to better direct their own services. Employ fiscal intermediary services to better provide services each person desires. Support their personal goals and evaluate their attainment.

Maintain the strict standards of the The Council on Quality and Leadership in Supports for People with Disabilities, a private organization that accredits organizations and agencies, which support persons with developmental disabilities. Increase accredited services to 100% coverage from the current 88%.

Budget for and support staff and provider training to improve quality.

Continue to work in partnership with providers and stakeholders to identify and increase the range and quality of services based on service users' goals.

Special Thanks To the Contributors

ACKNOWLEDGEMENTS

Production of a document of this kind involves the active participation of many individuals. The sum of their efforts is shown here. While the work of all of the people who contributed is greatly appreciated, a few individuals deserve special recognition.

Developmental Services program data and text was supplied by Peter Steinmann. Additional textual review, editing and enhancement for the section on developmental disabilities was provided by Dr. David Luke.

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THIS IS A REPRINT OF THE ORIGINAL VERSION: BECAUSE OF PRINTER DIFFERENCES THERE ARE SLIGHT DIFFERENCES IN PAGE BREAKS AND GRAPHIC POSITIONING. THERE HAS BEEN NO CONTENT CHANGE FROM THE ORIGINAL.

Troy Williams, Producer **12/23/2002**